Missouri

UNIFORM APPLICATION
FY 2006

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 08/26/2004 - Expires 08/31/2007

(generated on 10-13-2005 3.07.05 PM)

Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Missouri
DUNS Number: 780871430

Uniform Application for FY 2006 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Missouri Department of Mental Health

Organizational Unit: Division of Alcohol and Drug Abuse

Mailing Address: 1706 E Elm Street PO Box 687

City: Jefferson City Zip: 65102-0687

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Michael Couty

Agency Name: Missouri Department of Mental Health Div of Alcohol and Drug Abuse

Mailing Address: 1706 E Elm Street PO Box 687

City: Jefferson City Zip Code: 65102-0687

Telephone: (573) 751-9499 FAX: (573) 751-7814

III. STATE EXPENDITURE PERIOD

From: 7/1/2003 To: 6/30/2004

IV. DATE SUBMITTED

Date: 8/26/2005 ☒ Original ☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Michael Couty Telephone: (573) 751-9499

E-MAIL: michael.couty@dmh.mo.gov FAX: (573) 751-7814

Form 2 (Table of Contents)

State:
Missouri

UNIFORM APPLICATION FOR FY 2006 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as Required by the Public Health Service (PHS) Act

The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
State: Missouri	
Name of Chief Executive Officer or Designee: Dorn Schuffman	
Signature of CEO or Designee:	
Title: Director	**Date Signed:**
If signed by a designee, a copy of the designation must be attached	

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director

APPLICANT ORGANIZATION	DATE SUBMITTED
Department of Mental Health	

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
☐ Prime ☐ Subawardee Tier _____ , if known: _____ **Congressional District**, *if known:* _____	 **Congressional District**, *if known:* _____
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** if known:	9. **Award Amount,** if known: $
10. **a. Name and Address of Lobbying Entity** *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

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Approved by OMB No. 0348-0046

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

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Standard Form – LLL -A

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION Department of Mental Health	DATE SUBMITTED

State:
Missouri

FY 2003 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2003 is reflected on Line 8 of the Notice of Block Grant Award

$26,268,668

State:
Missouri

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☒ Yes ☐ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☐ Yes ☒ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT	OTHER STATE FUNDS	DRUG FREE SCHOOLS
☐ Yes	☐ Yes	☐ Yes
☒ No	☒ No	☒ No
☐ Unknown	☐ Unknown	☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☐ Yes ☒ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? ☒ Yes ☐ No ☐ Unknown

Dissemination of materials? ☒ Yes ☐ No ☐ Unknown

Media campaigns? ☒ Yes ☐ No ☐ Unknown

Product pricing strategies? ☒ Yes ☐ No ☐ Unknown

Policy to limit access? ☒ Yes ☐ No ☐ Unknown

6. Does your State now have laws that suspend or revoke administrative drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☒ Yes ☐ No ☐ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☐ Yes ☒ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☐ Yes ☒ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	☐	☐	☒	☐
Alcohol	☐	☐	☒	☐
Marijuana	☐	☐	☒	☐

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other durg abuse prevention (HP 26-3)? 138

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

State:
Missouri

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2005) to the fiscal year for which the State is applying for funds provide a description of the State's procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- ☒ Use model notice provided in final regulations.
- ☐ Use notice developed by State (attached copy).
- ☒ State has disseminated notice to religious organizations that are providers.
- ☒ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☒ State has incorporated this requirement into existing referral system(s).
- ☒ SAMHSA's Treatment Facility Locator is used to help identify providers.
- ☒ Other networks and information systems are used to help identify providers.
- ☒ State maintains record of referrals made by religious organizations that are providers.
- ☐ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Missouri was awarded $22.8 million over three years to implement a statewide voucher system for adults that affords genuine, free and independent choice among an increased number of qualified service providers; provides recovery support services through traditional, non-traditional and faith-based organizations; expands the existing managed care system for proper control and monitoring; and measures outcomes in seven critical domains. Faith organizations and other nontraditional providers interested in providing recovery support services under the Access to Recovery project are required to have a minimum of two staff or volunteers complete the Addictions Academy. Charitable Choice requirements are integrated into this training.

State:
Missouri

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))

☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))

☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as Attachment J to the application. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Missouri

Dates of State Expenditure Period:
From 7/1/2003 to 6/30/2004

Activity	A. SAPT Block Grant FY 2003 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$19,841,893	$22,202,423	$1,098,112	$24,292,141	$	$
2. Primary Prevention	$5,253,735		$2,284,869	$773,017	$	$
3. Tuberculosis Services	$27,644	$49,012	$	$31,960	$	$
4. HIV Early Intervention Services	$	$95,506	$	$1,368,284	$	$
5. Administration (excluding program/provider level)	$1,145,397		$432,078	$1,581,390	$	$
6. Column Total	$26,268,669	$22,346,941	$3,815,059	$28,046,792	$	$

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form 4 Footnotes
Other Federal Funds include 1) Cooperative Agreements for State Data Infrastructure (SAMHSA), 2) Co-occurring State Incentive Grant (COSIG - SAMSHA), 3) Enforcing Underage Drinking Laws (EUDL) Block Grant - (OJJDP), 4) Community Trials Initiative Discretionary EUDL Grant (OJJDP), 5) Safe and Drug Free Schools and Communities (Dept of Education), 6) Enhancing Community Support for Substance Abusing Youth (SAMSHA), 7) State Incentive Planning Grant (SAMSHA-CSAP), 8) Treatment Needs Assessment (SAMSHA), 9) Uniform Data Collection (DASIS).

Form 4a

Primary Prevention Expenditures Checklist

State:
Missouri

	Block Grant FY 2003	Other Federal	State	Local	Other
Information Dissemination	**$583,888**	**$347,067**	**$7,874**	**$**	**$**
Education	**$2,013,427**	**$591,616**	**$366,922**	**$**	**$**
Alternatives	**$408,855**	**$75,000**	**$441**	**$**	**$**
Problem Identification & Referral	**$4,855**	**$391**	**$171**	**$**	**$**
Community-Based Process	**$904,643**	**$474,271**	**$19,317**	**$**	**$**
Environmental	**$332,268**	**$608,918**	**$46,234**	**$**	**$**
Other	**$647,458**	**$185,097**	**$29,127**	**$**	**$**
Section 1926 - Tobacco	**$358,341**	**$2,509**	**$302,931**	**$**	**$**
TOTAL	**$5,253,735**	**$2,284,869**	**$773,017**	**$**	**$**

Form 4a Footnotes
Other Federal Funds include 1) Cooperative Agreements for State Data Infrastructure (SAMHSA), 2) Co-occurring State Incentive Grant (COSIG - SAMSHA), 3) Enforcing Underage Drinking Laws (EUDL) Block Grant - (OJJDP), 4) Community Trials Initiative Discretionary EUDL Grant (OJJDP), 5) Safe and Drug Free Schools and Communities (Dept of Education), 6) Enhancing Community Support for Substance Abusing Youth (SAMSHA), 7) State Incentive Planning Grant (SAMSHA-CSAP), 8) Treatment Needs Assessment (SAMSHA), 9) Uniform Data Collection (DASIS).

Form 4b

Resource Development Expenditure Checklist

State:
Missouri

Did your State fund resource development activities from the FY 2003 block grant?

☒ Yes ☐ No

	Treatment	Prevention	Total
Planning, Coordination and Needs Assessment	**$**	**$168,997**	**$168,997**
Quality Assurance	**$**	**$7,000**	**$7,000**
Training (post-employment)	**$16,875**	**$**	**$16,875**
Education (pre-employment)	**$**	**$37,212**	**$37,212**
Program Development	**$33,018**	**$158,416**	**$191,434**
Research and Evaluation	**$50,000**	**$63,904**	**$113,904**
Information Systems	**$**	**$**	**$**
TOTAL	**$99,893**	**$435,529**	**$535,422**

Expenditures on Resource Development Activities are:

☒ **Actual** ☐ **Estimated**

SUBSTANCE ABUSE ENTITY INVENTORY

State:
Missouri

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

					FISCAL YEAR 2003			
1. Entity Number	2. National Register (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
001	MO900305	Central Region	$817,878		$	$	$	$
008	x	Statewide (optional)	$207,511		$156,912	$	$478,916	$
009	MO901642	Eastern Region	$445,450		$	$	$	$
038	MO750502	Southeast Region	$377,697		$349,026	$	$	$
039	MO903879	Southwest Region	$		$2,563	$2,563	$	$
043	MO100948	Southwest Region	$159,667		$180,053	$	$145,237	$
152	X	Eastern Region	$109,224		$	$	$442,816	$
171	X	Northwest Region	$49,491		$	$	$252,344	$
174	MO103967	Eastern Region	$61,785		$55,841	$	$	$
175	MO903515	Southwest Region	$225		$18,928	$	$	$
183	MO100716	Northwest Region	$328,924		$384,169	$	$	$
185	X	Northwest Region	$8,881		$	$	$86,110	$

State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
189	MO100591	Eastern Region	$666,043		$307,276	$307,276	$	$
195	MO101151	Southwest Region	$30		$7,235	$	$	$
207	MO101482	Southwest Region	$75,662		$8,392	$	$	$
208	MO101490	Eastern Region	$248,517		$26,838	$	$	$
209	x	Southwest Region	$96,372		$19,502	$	$	$
211	X	Central Region	$82,300		$2,089	$	$	$
216	X	Northwest Region	$20,896		$1,966	$	$	$
217	X	Northwest Region	$61,861		$10,418	$	$	$
218	MO101714	Northwest Region	$1,380		$	$	$	$
219	X	Northwest Region	$5,769		$6,836	$	$	$
226	MO101755	Northwest Region	$35,604		$3,000	$	$	$
227	X	Eastern Region	$40,505		$4,330	$	$	$

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State:
Missouri

					FISCAL YEAR 2003			
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231	X	Central Region	$42,292		$21,788	$	$	$
238	MO102027	Eastern Region	$53,908		$4,603	$	$	$
239	MO101987	Eastern Region	$32,393		$9,055	$	$	$
252	X	Southeast Region	$76,076		$15,101	$	$	$
264	X	Southwest Region	$22,504		$5,714	$	$	$
267	X	Statewide (optional)	$		$159,367	$	$1,084,922	$
269	MO105087	Eastern Region	$289,965		$410,683	$	$	$
274	X	Southwest Region	$25,394		$5,243	$	$	$
302	X	Northwest Region	$		$	$	$81,917	$
045a	MO902608	Northwest Region	$23,288		$19,999	$	$	$
045b	MO102142	Northwest Region	$140,206		$120,404	$	$	$
045c	MO105244	Northwest Region	$216,725		$186,116	$	$	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
045d	MO902673	Northwest Region	$42,775		$36,734	$	$	$
049a	MO106614	Central Region	$4,976		$3,818	$	$316	$
049b	MO106218	Southeast Region	$85,007		$65,221	$	$5,391	$
049c	MO103801	Southwest Region	$52,663		$40,405	$	$3,340	$
049d	MO106259	Southwest Region	$4,561		$3,500	$	$289	$
049e	MO901527	Southwest Region	$381,495		$292,701	$	$24,194	$
056a	MO903598	Southeast Region	$15,193		$14,104	$5,987	$1,374	$
056b	MO100620	Southeast Region	$5,598		$5,196	$2,206	$506	$
056c	MO301793	Southeast Region	$649,317		$602,776	$255,876	$58,738	$
061a	MO101011	Central Region	$329,729		$277,035	$108,340	$	$
061b	MO103694	Central Region	$52,358		$43,990	$17,203	$	$
061c	MO106101	Central Region	$75,420		$63,367	$24,781	$	$

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State:
Missouri

					FISCAL YEAR 2003			
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062a	MO902269	Central Region	$438,662		$488,617	$488,617	$	$
062b	MO100179	Central Region	$257,742		$203,096	$	$96,068	$
062c	MO105475	Central Region	$39,327		$30,989	$	$14,658	$
067a	MO301603	Eastern Region	$318,737		$332,931	$	$	$
067b	MO100765	Eastern Region	$296,069		$425,131	$	$	$
067c	MO900081	Eastern Region	$163,885		$235,325	$	$	$
074a	MO103330	Northwest Region	$6,317		$2,341	$	$	$
074b	MO103348	Southwest Region	$3,350		$1,242	$	$	$
089a	MO750403	Eastern Region	$572,234		$452,314	$	$	$
089b	MO101417	Eastern Region	$		$11,191	$	$	$
090a	MO101136	Eastern Region	$587,577		$488,839	$228,051	$	$
090b	MO101458	Eastern Region	$256,747		$213,602	$99,649	$	$

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State:
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					FISCAL YEAR 2003			
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090c	MO106069	Eastern Region	$248,264		$206,545	$96,356	$	$
090d	MO100381	Eastern Region	$100,097		$83,277	$38,850	$	$
090e	MO102803	Eastern Region	$20,924		$17,408	$8,121	$	$
153a	MO106606	Central Region	$6,324		$3,667	$	$2,503	$
153b	MO105723	Central Region	$57,124		$100,402	$	$	$
153c	MO100567	Eastern Region	$371		$44,085	$	$	$
153d	MO000024	Eastern Region	$662,651		$672,016	$	$	$
153e	MO105715	Eastern Region	$215,352		$78,374	$	$	$
154a	MO100526	Northwest Region	$162,400		$219,813	$	$	$
154b	MO301785	Northwest Region	$385,934		$379,659	$	$	$
158a	MO000022	Southeast Region	$135,607		$119,296	$	$6,817	$
158b	MO103157	Southeast Region	$3,616		$3,181	$	$182	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
158c	MO902319	Southeast Region	$274,830		$241,773	$	$13,815	$
188a	MO102019	Northwest Region	$		$125,129	$	$	$
188b	MO100922	Southwest Region	$175,404		$97,585	$	$	$
210a	MO103884	Eastern Region	$91,125		$12,827	$	$	$
210b	MO106077	Eastern Region	$103,581		$14,580	$	$	$
249a	MO105434	Southeast Region	$20,977		$2,309	$	$	$
249b	MO105442	Southeast Region	$15,307		$1,685	$	$	$
021	MO102084	Northwest Region	$356,068		$893,160	$	$	$
037	MO750593	Southwest Region	$529,414		$365,674	$	$	$
048	MO101631	Southwest Region	$13,204		$5,855	$	$	$
049f	MO103918	Southwest Region	$32,759		$25,134	$	$2,078	$
049g	MO106309	Southwest Region	$42,711		$32,770	$	$2,709	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
049h	MO106242	Southwest Region	$33,588		$25,770	$	$2,130	$
049i	MO105798	Central Region	$20,733		$15,908	$	$1,315	$
049j	MO100404	Southeast Region	$38,564		$29,588	$	$2,446	$
049k	MO103207	Central Region	$148,037		$113,581	$	$9,388	$
049l	MO105814	Central Region	$24,465		$18,771	$	$1,552	$
049m	MO100321	Central Region	$20,319		$15,590	$	$1,289	$
049n	MO103272	Northwest Region	$34,417		$26,407	$	$2,183	$
049o	MO103124	Northwest Region	$30,685		$23,543	$	$1,946	$
049p	MO103280	Northwest Region	$159,233		$122,171	$	$10,098	$
049q	MO901543	Northwest Region	$87,495		$67,130	$	$5,549	$
049r	MO103231	Northwest Region	$36,905		$28,316	$	$2,340	$
049s	MO103215	Northwest Region	$72,567		$55,677	$	$4,602	$

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State:
Missouri

					FISCAL YEAR 2003			
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049t	MO103298	Central Region	$38,979		$29,906	$	$2,472	$
052a	MO103389	Southwest Region	$10,139		$9,613	$	$	$
052b	MO101631	Southwest Region	$19,744		$18,721	$	$	$
052c	MO000001	Southwest Region	$20,278		$19,227	$	$	$
052d	MO901501	Southwest Region	$352,197		$333,937	$	$	$
052e	MO100650	Southwest Region	$4,269		$4,048	$	$	$
053a	MO102159	Central Region	$359,046		$279,548	$	$	$
053b	MO750064	Central Region	$176,595		$137,494	$	$	$
055a	MO903911	Southeast Region	$284,460		$259,798	$	$	$
055b	MO103785	Southeast Region	$61,422		$56,097	$	$	$
055c	MO104593	Southeast Region	$154,707		$141,294	$	$	$
056d	MO000041	Southeast Region	$76,440		$100,479	$	$	$

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State:
Missouri

					FISCAL YEAR 2003			
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056e	MO101227	Southeast Region	$118,348		$109,865	$46,638	$10,706	$
056f	MO101128	Southeast Region	$296,670		$275,406	$116,909	$26,837	$
056g	MO105640	Southeast Region	$30,387		$28,209	$11,974	$2,749	$
056h	MO100649	Southeast Region	$5,598		$5,196	$2,206	$506	$
057a	MO100872	Northwest Region	$565,620		$	$	$	$
057b	MO106010	Northwest Region	$25,063		$32,512	$	$	$
057c	MO101094	Northwest Region	$343,510		$498,069	$497,978	$	$
058a	MO100518	Northwest Region	$147,958		$220,919	$	$	$
058b	MO301678	Northwest Region	$873,772		$699,877	$254,227	$	$
058c	MO100914	Northwest Region	$16,440		$24,547	$	$	$
061d	MO750098	Central Region	$619,566		$520,554	$203,573	$	$
061e	MO106671	Central Region	$116,558		$97,931	$38,298	$	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
062d	MO750056	Central Region	$13,311		$10,489	$	$4,961	$
062f	MO100187	Central Region	$234,751		$184,980	$	$87,498	$
074c	MO100930	Southwest Region	$21,727		$8,052	$	$	$
082a	MO901592	Eastern Region	$281,546		$197,877	$	$	$
082b	MO103009	Eastern Region	$98,989		$139,755	$	$	$
082c	MO100503	Eastern Region	$45,507		$64,248	$	$	$
082d	MO102209	Eastern Region	$281,546		$197,877	$	$	$
087a	MO106598	Northwest Region	$539,875		$436,497	$	$180,063	$
087b	MO903127	Northwest Region	$75,538		$61,074	$	$25,194	$
153f	MO105046	Central Region	$53,223		$30,861	$	$21,064	$
153g	MO105780	Central Region	$41,630		$24,138	$	$16,476	$
153h	MO103942	Central Region	$23,186		$13,444	$	$9,176	$

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153i	MO101797	Central Region	$5,797		$3,361	$	$2,294	$
153j	MO105038	Northwest Region	$30,037		$17,416	$	$11,887	$
153k	MO101169	Central Region	$389,422		$225,802	$	$154,119	$
153l	MO105210	Northwest Region	$92,218		$53,471	$	$36,496	$
153m	MO103892	Northwest Region	$36,360		$21,083	$	$14,390	$
153n	MO103900	Northwest Region	$373,550		$320,900	$	$	$
153o	MO000025	Northwest Region	$168,555		$101,351	$	$	$
153p	MO101177	Northwest Region	$67,978		$39,416	$	$26,903	$
153q	MO100668	Central Region	$18,444		$10,694	$	$7,299	$
154c	MO101441	Northwest Region	$79,069		$96,274	$	$	$
156a	MO100264	Southwest Region	$11,728		$10,282	$10,282	$	$
156b	MO101029	Southwest Region	$330,591		$289,819	$289,819	$	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
156c	MO100287	Southwest Region	$21,991		$19,278	$19,278	$	$
158d	MO105095	Southeast Region	$11,527		$10,140	$	$579	$
158e	MO102571	Southeast Region	$37,744		$33,204	$	$1,897	$
158f	MO106705	Southeast Region	$98,315		$86,489	$	$4,942	$
158g	MO903853	Southeast Region	$380,378		$334,625	$	$19,121	$
158h	MO000021	Southeast Region	$69,612		$61,238	$	$3,499	$
158i	MO105178	Southeast Region	$4,068		$3,579	$	$205	$
158j	MO103140	Southeast Region	$6,102		$5,368	$	$307	$
158k	MO103165	Southeast Region	$4,746		$4,175	$	$239	$
173	MO903788	Eastern Region	$396,768		$415,531	$189,983	$	$
210c	MO103462	Eastern Region	$117,348		$16,518	$	$	$
210d	MO101623	Eastern Region	$162,582		$22,885	$	$	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
220	X	Central Region	$3,643		$2,599	$	$	$
249c	MO105426	Eastern Region	$6,236		$686	$	$	$
249d	MO102035	Eastern Region	$554,472		$61,029	$	$	$
249e	MO105459	Eastern Region	$22,111		$2,434	$	$	$
250	MO102050	Northwest Region	$385,492		$143,530	$	$	$
262	MO102928	Eastern Region	$1,000,650		$146,081	$	$	$
276	MO100849	Southwest Region	$275,347		$325,830	$	$	$
311a	MO100624	Northwest Region	$57,378		$32,908	$	$	$
311b	MO100623	Northwest Region	$244,700		$140,342	$	$	$
312	MO100622	Southwest Region	$327,121		$341,813	$339,858	$	$
313	X	Northwest Region	$74,982		$10,429	$	$	$
400	X	Eastern Region	$		$	$	$140,746	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
401	X	Eastern Region	$		$	$	$4,369	$
402	X	Statewide (optional)	$		$	$	$135,045	$
403	X	Southeast Region	$		$	$	$99,166	$
404	X	Southeast Region	$		$	$	$159,352	$
405	X	Northwest Region	$		$	$	$300,000	$
406	x	Eastern Region	$		$	$	$39,294	$
407	x	Statewide (optional)	$45,154		$	$	$329,979	$
408	x	Statewide (optional)	$		$	$	$37,212	$
409	x	Southwest Region	$46,024		$	$	$209,596	$
410	x	Southeast Region	$19,076		$	$	$48,822	$
411	x	Southeast Region	$16,862		$	$	$74,275	$
412	x	Southwest Region	$72,336		$	$	$84,233	$

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State:
Missouri

					FISCAL YEAR 2003			
1. Entity Number	2. Inventory of Substance Abuse Treatment Services (I-SATS) ID	3. Area Served	4. State Funds		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
413	x	Statewide (optional)	$		$	$	$30,371	$
414	x	Eastern Region	$		$	$	$39,318	$
415	x	Statewide (optional)	$		$20,000	$	$	$
416	x	Statewide (optional)	$		$13,018	$	$	$
417	x	Statewide (optional)	$		$26,832	$	$	$
418	x	Statewide (optional)	$9,495		$	$	$	$
419	x	Statewide (optional)	$85,687		$	$	$	$
420	x	Statewide (optional)	$49,897		$	$	$	$
TOTAL	TOTAL	TOTAL	$26,465,402		$19,869,537	$3,704,899	$5,253,735	$

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Form 6 Footnotes
Data listed in column 5a is not mutually exclusive of the expenditures reported in column 5. As indicated in the instructions for this form, the data is entered twice, first in column 5 and again in column 5a.

PROVIDER ADDRESS TABLE

State:
Missouri

Provider ID	Description	Provider Address
008	Central Office	1706 East Elm Street, Jefferson City, MO, 65101, 573-751-4942,
152	St Louis Area Nation Council on ADA	8790 Manchester Road, St. Louis, , 63144, 314-962-3456,
171	National Council on ADA GR KC	633 East 63rd Street, Suite 511, Kansas City, , 64110, 816-361-5900,
185	Tri County Community MHS	3100 NE 83rd Street, Suite 1001, Kansas City, , 64119, 816-468-0400,
209	Safety Council of the Ozarks	1111 S. Glenstone, Springfield, , 65804, 417-869-2121,
211	Affiliated Court Servies	800 North Providence, Columbia, MO, 65201, 573-499-3784,
216	CAAREC	326 Cherry, Chilicothe, , 64601, 660-646-1652,
217	Central States MH Cons	3217 South Owens Road, Independence, MO, 64057, 816-224-4417,
219	County Court Services	PO Box 32267, Kansas City, MO, 64171, 816-474-2121,
227	Safety Council of Gr Stl	1015 Locust St., Suite 902, St. Louis, , 63101, 314-621-9200,
231	Traffic Safety Awareness Prog	PO Box 575, Linn Creek, , 65052, 573-346-3829,
252	Accredited Traffic Offenders	1515 E. Malone, Sikeston, , 63801, 573-471-7710,
264	Door To Hope	1714 Camp Clark Hill, Galena, MO, 65656-0015, 417-357-6263,
267	MO Association for Community Task Force	428 East Capitol Avenue, Second Floor, Jefferson City, MO, 65101, 573-635-6669,
274	Alcohol Drug Consultants	1736 E. Sunshine, Ste. 214, Springfield, , 65804, 417-848-4565,
302	Community Movement - Move Up	3330 Troost Avenue, Kansas City, MO, 64109, 816-842-8515,
220	Rasse, David R. and Assoc.	78 West Arrow Street, PO Box 38, Marshall, MO, 65340, 660-886-3373,
313	ADAPT, LLC	616 East 63rd STreet, Kansas City, , 64110, 816-523-4000,
400	Friends with a Better Plan	5622 Delmar, Suite 102E, St Louis, MO, 63112, 314-361-2371,
401	IAM Cares	230 South Bemiston, Ste 1006, St Louis, MO, 63105, 314-721-8116,

Provider ID	Description	Provider Address
402	L.E.A.D. Institute, The	311 Bernadette Drivw, Ste C, Columbia, MO, 65203, 573-445-5005,
403	Lincoln University	Business & Finance, 306 Young Hall, Jefferson City, MO, 65102, 573-681-558,
404	Mississippi County 33rd Circuit Ct	PO Box 369, Charleston, MO, 63834, 573-683-2146,
405	Mo Alliance of Boys/Girls Club	6301 Rockhill Road, Ste 303, Springfield, MO, 64131, 816-361-3600,
406	St Louis Department of Health	634 North Grand, St Louis, MO, 63178, 314-658-1140,
407	University of Missouri - Columbia	Office of Sponsored Programs, 310 Jessie, Columbia, MO, 65211, 573-882-7560,
408	William Woods University	One University Avenue, Fulton, MO, 65251-1098, 573-592-1127,
409	United Way of the Ozarks	330 N. Jefferson, Springfield, MO, 65806-1109, 417-863-7700,
410	Southeast Mo State University	One University Plaza, Cape Girardeau, MO, 63701, 573-651-2196,
411	Prevention Consultants of MO	104 East 7th Street, Rolla, MO, 65401, 573-368-4755,
412	Community Partnership of Ozarks	330 N Jefferson, Springfield, MO, 65806, 417-863-7700,
413	University of Oklahoma	Office of Proj & Comp Ass., 660 Parrington Ova, Norman, OK, 73019,
414	Discovering Options	909 Purdue Avenue, St Louis, MO, 63130, 314-721-8116,
415	Community Housing Network	2600 East 12th Street, Kansas City, MO, 64127, 816-482-5744,
416	Covington Burling	1201 Pennsylvania Ave, NW, Washington, DC, 20044, 202-662-5410,
417	Oxford House, Inc.	1010 Wayne Avenue, Ste 400, Silver Spring, MD, 20910,
418	Ozarks Area Community Action	215 South Barnes Avenue, Springfield, MO, 65802-2204, 417-862-4314,
419	SAVE, Inc.	PO Box 45301, Kansas City, MO, 64171, 816-531-8340,
420	Office of State Court Administrators	2212 Industrial, PO BOx 104480, Jefferson City, MO, 65102, 573-751-4377,

Prevention Strategy Report

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Mentors [15]	3
	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Pregnant Women/Teens [2]	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Drop-Outs [3]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Media campaigns [3]	3
	Information lines/Hot lines [8]	1
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	0
	Drug free dances and parties [21]	2
	Community service activities [24]	12
	Recreation activities [26]	5
	Student Assistance Programs [32]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
Violent and Delinquent Behavior [4]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	2
	Community service activities [24]	12
	Recreation activities [26]	5

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Violent and Delinquent Behavior [4]	Driving while under the influence/driving while intoxicated education programs [33]	12
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Accessing services and funding [45]	12
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	12
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Economically Disadvantaged [6]	Resources directories [2]	16

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	2
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Systematic planning [42]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Physically Disabled [7]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	0
	Brochures [4]	2
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	1

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Physically Disabled [7]	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Abuse Victims [8]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Already Using Substances [9]	Resources directories [2]	16
	Media campaigns [3]	2

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Already Using Substances [9]	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	5
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Community service activities [24]	2
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	16
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Media campaigns [3]	0
	Brochures [4]	22
	Radio and TV public service announcements [5]	1

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Homeless and/or Run away Youth [10]	Information lines/Hot lines [8]	1

TREATMENT UTILIZATION MATRIX

State:
Missouri

Dates of State Expenditure Period:
From 7/1/2003 to 6/30/2004 (Same as Form 1)

			Costs Per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons Served**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24 hour Care)					
1. Hospital Inpatient			**$.00**	**$.00**	**$.00**
2. Free-standing Residential	**8,125**	**5,763**	**$222.00**	**$181.00**	**$108.00**
Rehabilitation / Residential					
3. Hospital Inpatient			**$.00**	**$.00**	**$.00**
4. Short-term (up to 30 days)	**7,162**	**7,517**	**$1,046.00**	**$1,053.00**	**$510.00**
5. Long-term (over to 30 days)	**1,074**	**945**	**$1,849.00**	**$2,014.00**	**$683.00**
Ambulatory (Outpatient)					
6. Outpatient	**15,512**	**26,173**	**$343.00**	**$157.00**	**$136.00**
7. Intensive Outpatient	**19,879**	**16,452**	**$2,160.00**	**$1,287.00**	**$317.00**
8. Detoxification			**$.00**	**$.00**	**$.00**
Methadone	**381**	**955**	**$1,927.00**	**$2,187.00**	**$66.00**

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form 7b

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:
Missouri

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

AGE GROUP	A. TOTAL	B. White		C. Black		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	3,635	1,839	963	546	130	1	2	5	2	10	10	27	15	56	29	2,410	1,113	74	38
2. 18-24	8,234	4,614	1,774	1,191	448	12	3	12	5	17	14	22	11	76	35	5,849	2,228	95	62
3. 25-44	21,539	10,105	5,112	3,713	2,139	20	4	15	7	59	45	18	7	226	69	13,834	7,264	322	119
4. 45-64	5,894	2,955	954	1,416	479	5	3	5		15	4	3	1	48	6	4,361	1,426	86	21
5. 65 and over	163	106	15	34	7									1		137	22	4	
6. Total	39,465	19,619	8,818	6,900	3,203	38	12	37	14	101	73	70	34	407	139	26,591	12,053	581	240
7. Pregnant Women	350		235		108						3		1		3		344		6

Did the State base the values reported on Form 7A and 7B from a client-based system(s) with unique client identifiers?

☒ **Yes** ☐ **No**

State:
Missouri

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2003) + B2(2004) / 2 (C)
SFY 2003 (1)	$36,295,542	
SFY 2004 (2)	$36,595,848	$36,445,695
SFY 2005 (3)	$37,041,952	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2003 ☒ **Yes** ☐ **No**

FY 2004 ☒ **Yes** ☐ **No**

FY 2005 ☒ **Yes** ☐ **No**

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2005 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ **Yes** ☒ **No** **If yes, specify the amount** $0

Did the State include these funds in previous year MOE calculations? ☐ **Yes** ☒ **No**

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

TB (MOE Table II)

State:
Missouri

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	$140,610	17.6%	$24,747	
SFY 1992 (2)	$190,559	17.6%	$33,538	$29,143

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2005 (3)	$925,524	5.751666068%	$53,233

HIV (MOE Table III)

State:
Missouri

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B)
SFY1993 (1)	$298,242	
SFY1994 (2)	$304,625	$301,434

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2005 (3)	$0

*** Provided to substance abusers at the site at which they receive substance abuse treatment**

HIV (MOE Table III) Footnotes
Missouri is not a designated state.

Womens (MOE TABLE IV)

State:
Missouri

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	$7,728,020	
2003		$9,430,672
2004		$9,902,206
2005		$8,163,936

Enter the amount the State plans to expend in FY 2006 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $9,196,845

State:
Missouri

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2006 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

3 Population levels, Specify formula:
2004 population estimates of Service Areas

3 Incidence and prevalence levels

4 Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

5 Problem levels as estimated by social indicator data

5 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specific method)
Maintenance of existing services

2 Size of gaps between resources (as measured by)
Number of clients served in last fiscal year

and needs (as estimated by)
2003 STNAP-II prevalence estimates

_ Other (specify):

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Missouri	2003

1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Northwest Region	1,386,241	83,791	5,698	3,001	1,262	24,679	1,739	9,131	12,265	43	8	8	3
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Central Region	759,510	84,530	9,690	1,625	511	22,998	2,292	5,410	4,447	360	7	3	1
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Eastern Region	2,031,637	203,724	17,841	4,376	1,786	62,091	6,556	10,225	15,522	14	4	10	2
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Southwest Region	842,252	58,774	3,587	1,875	57	17,401	1,088	7,593	5,534	44	7	4	3

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Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Missouri	2003

1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Southeast Region	684,844	60,405	3,999	1,500	153	17,496	1,339	5,071	5,071	9	7	2	2

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: Boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
State Total	5,704,484	491,224	40,815	12,377	3,769	144,665	12,123	37,430	42,839	470	6	7	2

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Treatment Needs by Age, Sex, and Race/Ethnicity

State:	Substate Planning Area [95]:
Missouri	State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	29,377	14,982	7,603	0	0	0	0	0	0	0	0	0	0	5,314	1,478	0	0	0	0
2. 18 - 24	135,537	78,667	35,880	0	0	0	0	0	0	0	0	0	0	14,415	6,575	0	0	0	0
3. 25 - 44	209,213	121,429	55,384	0	0	0	0	0	0	0	0	0	0	22,251	10,149	0	0	0	0
4. 45 - 64	89,080	51,703	23,582	0	0	0	0	0	0	0	0	0	0	9,474	4,321	0	0	0	0
5. 65 and over	28,017	16,261	7,417	0	0	0	0	0	0	0	0	0	0	2,980	1,359	0	0	0	0
6. Total	491,224	283,042	129,866											54,434	23,882				

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Form 11

State:
Missouri

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

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SOURCE OF FUNDS

(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2006 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$19,693,078	$44,404,846	$2,196,224	$48,584,282	$0	$0
2. Primary Prevention	$5,266,231		$4,569,738	$1,546,034	$0	$0
3. Tuberculosis Services	$55,288	$98,024	$0	$63,920	$0	$0
4. HIV Early Intervention Services	$0	$191,012	$0	$2,736,568	$0	$0
5. Administration (excluding program/provider level)	$1,316,557		$864,156	$3,162,780	$0	$0
6. Column Total	$26,331,154	$44,693,882	$7,630,118	$56,093,584	$	$

Form 11a

Primary Prevention Planned Expenditures Checklist

State:
Missouri

	Block Grant FY 2006	Other Federal	State	Local	Other
Information Dissemination	**$585,277**	**$694,134**	**$15,748**	**$**	**$**
Education	**$2,018,216**	**$1,183,232**	**$733,844**	**$**	**$**
Alternatives	**$409,827**	**$150,000**	**$882**	**$**	**$**
Problem Identification & Referral	**$4,867**	**$782**	**$342**	**$**	**$**
Community-Based Process	**$906,795**	**$948,542**	**$38,634**	**$**	**$**
Environmental	**$333,058**	**$1,217,836**	**$92,468**	**$**	**$**
Other	**$648,998**	**$370,194**	**$58,254**	**$**	**$**
Section 1926 - Tobacco	**$359,193**	**$5,018**	**$605,862**	**$**	**$**
TOTAL	**$5,266,231**	**$4,569,738**	**$1,546,034**	**$**	**$**

Form 11a Footnotes
State:
General Revenue
Healthy Family Trust

Other Federal:
Statewide Prevention Framework State Incentive Grant (SAMHSA - CSAP)
Enforcing Underage Drinking Laws (EUDL) Block Grant--Department of Justice Office of Justice Programs, Office of Juvenile Justice Delinquency Prevention (OJJDP)
Community Trials Initiative (EUDL Discretionary grant) OJJDP
Safe and Drug Free Schools and Communities--Dept of Education

Form 11b

Planned Expenditures on Resource Development Activities

State:
Missouri

Does your State plan to fund resource development activities with FY 2006 funds?

☒ Yes ☐ No

	Treatment	Prevention	Total
Planning, Coordination and Needs Assessment	**$**	**$300,000**	**$300,000**
Quality Assurance	**$**	**$7,000**	**$7,000**
Training (post-employment)	**$50,000**	**$**	**$50,000**
Education (pre-employment)	**$**	**$**	**$**
Program Development	**$46,667**	**$174,344**	**$221,011**
Research and Evaluation	**$100,000**	**$450,000**	**$550,000**
Information Systems	**$**	**$**	**$**
TOTAL	**$196,667**	**$931,344**	**$1,128,011**

Form 12

State:
Missouri

TREATMENT CAPACITY MATRIX

This form contains data covering a 24 month projection for the period during which your principal agency of the State is permitted to spend the FY 2006 block grand award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient		
2. Free-standing Residential	**16,250**	**11,526**
Rehabilitation / Residential		
3. Hospital Inpatient		
4. Short-term (up to 30 days)	**14,324**	**15,034**
5. Long-term (over to 30 days)	**2,148**	**1,890**
Ambulatory (Outpatient)		
6. Outpatient	**31,024**	**52,346**
7. Intensive Outpatient	**39,758**	**32,904**
8. Detoxification		
Methadone	**762**	**1,910**

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State:
Missouri

Purchasing Services

Methods for Purchasing This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2006 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐	Competitive grants	Percent of Expense: %
☒	Competitive contracts	Percent of Expense: 99%
☐	Non-competitive grants	Percent of Expense: %
☒	Non-competitive contracts	Percent of Expense: 1%
☐	Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐	Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐	According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐	Line item program budget	Percent of Clients Served: % Percent of Expenditures: %
☐	Price per slot	Percent of Clients Served: % Percent of Expenditures: %

	Rate:	Type of slot:
	Rate:	Type of slot:
	Rate:	Type of slot:

☒	Price per unit of service	Percent of Clients Served: 100% Percent of Expenditures: 100%
	Unit: hour	Rate: 45.12
	Unit: hour	Rate: 10.1
	Unit: day	Rate: 5.07

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Program Performance Monitoring

☒ On-site inspections

(Frequency for treatment:) Annually

(Frequency for prevention:) Annually

☒ Activity Reports

(Frequency for treatment:)

(Frequency for prevention:) Monthly

☒ Management information System

☒ Patient/participant data reporting system

(Frequency for treatment:) Monthly

(Frequency for prevention:) Monthly

☒ Performance Contracts

☒ Cost reports

☒ Independent Peer Review

☒ Licensure standards - programs and facilities

(Frequency for treatment:) 3 Year program certification

(Frequency for prevention:) 3 Year program certification

☒ Licensure standards - personnel

(Frequency for treatment:) Semi-annually Quality of Care Review

(Frequency for prevention:) N/A

☒ Other (Specify): Pre-test/Post-test - Prevention

State:
Missouri

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T1 - TREATMENT PERFORMANCE MEASURE
EMPLOYMENT STATUS (From Admission to Discharge)

Employment Status - Clients employed (full-time or part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients employed (full-time and part-time) [numerator]	9,360	10,280	
Total number of clients with non-missing values on employment status [denominator]	28,668	28,668	
Percent of clients employed (full-time and part-time)	32.65%	35.86%	3.21% / 9.83%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T1.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify

T1.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T1.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T1.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T1.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

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State Description of Employment Status Data Collection (Form T1)

GOAL

To improve the employment status of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being employed (including part-time) at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on employment that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S)	Source(s): CTRAC
DATA ISSUES	Issues: NONE
DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

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Form T1 Footnotes
The total number of clients with non-missing values on employment status (denominator) includes those not in the labor force.

State:
Missouri

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T2 - TREATMENT PERFORMANCE MEASURE
HOMELESSNESS: Living Status (From Admission to Discharge)

Homelessness - Clients homeless (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients homeless [numerator]	0	0	
Total number of clients with non-missing values on living arrangements [denominator]	0	0	
Percent of clients homeless			0.00% / 0.00%

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THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T2.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T2.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☒ Other: Specify Unable to collect at discharge

T2.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T2.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T2.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☒ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

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State Description of Homelessness (Living Status) Data Collection (Form T2)*

GOAL

To improve the living conditions of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being homeless at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☐ NO ☒

State collects admission and discharge data on living status that can be reported using TEDS definitions.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	Source(s):	
DATA ISSUES	Issues:	Living status data is not collected at discharge. It is anticipated that the state will have the infrastructure in place to capture living status at admission and discharge within the next fiscal year and will be able to report this measure the following fiscal year. The state is currently developing a new information system which will provide this capability.

DATA PLANS IF DATA IS NOT AVAILABLE

State should provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

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State:
Missouri

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T3 - TREATMENT PERFORMANCE MEASURE
CRIMINAL JUSTICE INVOLVEMENT (From Admission to Discharge)

Arrests - Clients arrested (any charge) (in prior 30 days) at admission vs. discharge - T3	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of Clients arrested [numerator]	21,626	817	
Total number of clients with non-missing values on arrests [denominator]	29,798	29,798	
Percent of clients arrested	72.58%	2.74%	-69.83% / -96.22%

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THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T3.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify

T3.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T3.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T3.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T3.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Number of Arrests Data Collection (Form T3)

GOAL

To reduce the criminal justice involvement of persons treated in the States substance abuse treatment system.

MEASURE

The change in persons arrested in the last 30 days at discharge for all clients receiving treatment.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on criminal justice involvement that can be reported as a Yes/No response.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S)	Source(s): CTRAC
DATA ISSUES	Issues: States will need to discuss if information on all arrests is not available. The state currently collects arrests during the past 2 years. When the state's new information system goes into production, collection of arrests in the past 30 days will begin. It is anticipated that the new information system will go into production during the next fiscal year.
DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

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State:
Missouri

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T4 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - ALCOHOL USE (From Admission to Discharge)

Alcohol Abstinence - Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from alcohol [numerator]	11,543	17,295	
Total number of clients with non-missing values on 'used any alcohol' variable [denominator]	27,517	27,517	
Percent of clients abstinent from alcohol	41.95%	62.85%	20.90% / 49.83%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T4.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T4.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T4.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T4.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T4.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Alcohol Use Data Collection (Form T4)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change of all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on alcohol use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S)	Source(s): CTRAC
DATA ISSUES	Issues: NONE

DATA PLANS IF DATA IS NOT AVAILABLE

State should provide time-framed plans for capturing alcohol use data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Missouri

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T5 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - OTHER DRUG USE (From Admission to Discharge)

Drug Abstinence - Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from illegal drugs [numerator]	14,759	19,196	
Total number of clients with non-missing values on 'used any drug' variable [denominator]	27,643	27,643	
Percent of clients abstinent from drugs	53.39%	69.44%	16.05% / 30.06%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T5.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T5.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T5.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☒ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T5.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T5.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Other Drug Use Data Collection (Form T5)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on other drug use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S)	Source(s): CTRAC
DATA ISSUES	Issues: NONE
DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing other drug use data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form T6

State:
Missouri

Voluntary Form T6 - Infectious Diseases Performance Measure

This goal of this form is to determine the degree to which the Single State Agency provides and/or coordinates delivery of appropriate infection control practices within its service system for substance abuse treatment and prevention services. This form is a checklist to be completed by the Single State Agency (SSA). For each item, please check the box that best relates the degree to which that item describes the State Infectious Disease control program/practices. The SSA should develop a method for self-assessment to examine its policies, procedures and services relevant to infectious disease control. The SSA should attempt to use the same self-assessment criteria from year to year. The SSA should perform this assessment annually.

LEGEND: 0-Not addressed; 1-Inadequately addressed; 2-Adequately addressed; and 3-Completely addressed
(Select one for each response to questions 1-8)

CHARACTERISTICS DOCUMENTING APPROPRIATE PRACTICES IN INFECTIOUS DISEASES CONTROL

0 1 2 3

☐ ☐ ☐ ☒ 1. Single State Agency (SSA) maintains Memoranda of Understanding (MOU) and/or other formal arrangements with appropriate public health agencies and other social service providers to provide continuum of care for persons with substance use disorders who are also at risk for infectious diseases including screening, assessment, referral and treatment for infectious diseases and preventive practices to control disease transmission.

Specify MOUs and other formal agreements maintained:

Missouri Department of Mental Health, Division of Alcohol and Drug Abuse (ADA) and the Department of Health and Senior Services (DHSS) have formalized a Memoranda of Understanding that is in effect to strengthen community access to and utilization of HIV prevention and care services, STD, Hepatitis, and TB education, screening, and treatment services.

0 1 2 3

☐ ☐ ☒ ☐ 2. Single State Agency (SSA) or other State agency certification, licensure or contract provisions require infectious disease control procedure/policies (infectious disease control standards) at the provider level.

Single State Agency or other State agency monitors provider implementation of policies/procedures.

Specify licensure; certification; or contract provision(s)

Contractual agreements require establishment and maintenance of service linkages with community health providers to ensure client access to necessary Tuberculosis services.

Specify authority administering licensure; certification; or contract process

Department of Mental Health

Specify monitoring activity(ies)

The annual monitoring process includes components of representative sampling of the ADA contracted providers, billing process, and a review of client records to ensure that Tuberculosis services are consistently and effectively provided by all ADA contracted providers.

Specify proportion of programs meeting or exceeding infectious disease control standards during compliance monitoring

100%

CHARACTERISTICS OF HUMAN IMMUNODEFICIENCY VIRUS AND TUBERCULOSIS CONTROL ACTIVITY

YES	NO	
☐	☒	Is the State a 'designated State' (i.e., cumulative case rate is equal to or greater than 10/100,000)?

YES	NO	
☐	☒	Was the State a 'designated State' (i.e., cumulative case rate is equal to or greater than 10/100,000) in at least one of the last two years?

YES	NO	
☐	☒	If the State is a designated State, have HIV infection procedures been developed by the principal agency for substance abuse in consultation with the State Medical Director and in cooperation with the State Department of Health/Communicable Disease Officer?

Whether or not the State is a 'designated State':

0	1	2	3		
☐	☐	☒	☐	3.	Are early intervention services(EIS) projects provided at the site where individuals are undergoing substance abuse treatment?

Specify the number of substance abuse treatment sites providing EIS:

115

If the State funds more than one EIS project, specify number of such substance abuse treatment sites that are located in a rural area(s):

65

0	1	2	3		
☐	☐	☒	☐	4.	Do these sites have established linkages with a comprehensive community resource network of related health and social service organizations?

0	1	2	3		
☐	☐	☒	☐	5.	Do State funded substance abuse programs provide on-site or through referral:

(A) Appropriate pre-test and post-test counseling for HIV and AIDS;

(B) testing individuals with respect to such disease, including tests to diagnose the extent of the deficiency, tests to provide information on appropriate therapeutic measures, and for preventing and treating conditions arising from the disease; and

(C) providing the therapeutic measures described in (B).

0	1	2	3		
☐	☐	☐	☒	6.	Are tuberculosis services as described in 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.121 and 96.127, routinely made available, directly or through arrangement with other public or nonprofit private entities, to each individual receiving substance abuse treatment services?

0 1 2 3

☐ ☐ ☒ ☐ 7. Have infection control procedures as described in 45 C.F.R. 96.127(a)(3) been established by the principal agency of the State for substance abuse, in cooperation with the State Medical Director and in cooperation with the State Department of Health/Tuberculosis Control Officer that which are designed to prevent the transmission of tuberculosis?

Specify the proportion of sites providing screening services directly or through referral:

100%

Specify the proportion of sites providing case management activities as described in 45 C.F.R. 96.127(a)(4) of clients with TB to ensure that individuals receive necessary services:

%

0 1 2 3

☐ ☐ ☐ ☒ 8. Have effective strategies been developed for monitoring programs compliance with 45 C.F.R. 96.121 and 96.127?

Specify the procedures utilized:

Annual billing audits identify that services are provided according to contractual requirements. Site certification and Safety and Basic Assurances Review monitoring practices include compliance of 45 C.F.R. parts in 96.121 and 96.127.

YES	NO	
☒	☐	Licensure or program certification standards
☒	☐	Contract or grant specifications/requirements
☒	☐	On-site monitoring
☒	☐	Client records audits

Total: 19

Total the numbers in the boxes (possible 0-24) and enter the number in the total cell.

Form T6 Footnotes
2) All ADA contracted providers receive either a full Certification Survey monitoring review or a Safety and Basic Assurance Review (SBAR) visit, which reviews the provision of TB screening and referral process. All ADA contracted providers also receive billing audits to review the consistency of provision of risk assessment and screening for infectious diseases to include Tuberculosis. During the annual monitoring process, none of the contracted providers were found to be deficient in meeting infectious disease control standards.

3) Rural area is defined as a city with a population under 35,000. Missouri has 18 cities with population greater than 35,000, which are classified as urban. These include Kansas City, St Louis, Springfield, Independence, Columbia, St Joseph, Lee's Summit, St Charles, St Peters, Florissant, Blue Springs, Chesterfield, O'Fallon, Joplin, Jefferson City, University City, Cape Girardeau, and Oakville.

7) During the annual monitoring process, none of the contracted providers were found to be deficient in providing screening services or identifying individuals who are at high risk. ADA currently provides case management for clients with an infectious disease or at risk for an infectious disease, however, the type of infectious disease is not specified.

State:
Missouri

Reporting Period:
From 7/1/2003 To 6/30/2004

FORM T7 - PERFORMANCE MEASURE
CHANGE IN SOCIAL SUPPORT OF RECOVERY (From Admission to Discharge)

Social Support of Recovery - Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	0	0	
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	0	0	
Percent of clients participating in social support activities			0.00% / 0.00%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T7.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T7.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☒ Other: Specify Data not available

T7.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T7.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T7.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☒ Information is not collected at Admission
- ☒ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Social Support of Recovery Data Collection (Form T7)

GOAL

To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported participation in one or more social and or recovery support activity at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission and discharge data on social support of recovery that can be reported using definitions provided as follows:

Participation in social support of recovery activities are defined as attending self-help, attending religious/faith affiliated recovery or self help groups, attending meetings of organizations other than the organizations described above or interactions with family members and/or friends supportive of recovery.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S)	Source(s):	
DATA ISSUES	Issues:	It is anticipated that the state will have the infrastructure in place to capture this data at admission and discharge within the next fiscal year and will be able to report this measure the following fiscal year. The state is currently developing a new information system which will provide this capability.

DATA PLANS IF DATA IS NOT AVAILABLE

State should provide time-framed plans for capturing social support of recovery data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Missouri

FORM T8: RETENTION

Length of Stay (in Days) of Clients Completing Treatment

Length of Stay			
LEVEL OF CARE	**AVERAGE**	**MEDIAN**	**STANDARD DEVIATION**
DETOXIFICATION (24 HOUR CARE)			
1. Hospital Inpatient	**0**	**0**	**0**
2. Free-standing Residential	**0**	**0**	**0**
REHABILITATION / RESIDENTIAL			
3. Hospital Inpatient	**0**	**0**	**0**
4. Short-term (up to 30 days)	**0**	**0**	**0**
5. Long-term (over 30 days)	**0**	**0**	**0**
AMBULATORY (OUTPATIENT)			
6. Outpatient	**0**	**0**	**0**
7. Intensive Outpatient	**0**	**0**	**0**
8. Detoxification	**0**	**0**	**0**
9. Methadone	**0**	**0**	**0**

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form T8 Footnotes
It is anticipated that the state will have the infrastructure in place to capture this data at admission and discharge within the next fiscal year and will be able to report this measure the following fiscal year. The state is currently developing a new information system which will combine its service transaction data and its program admission/discharge data.

State:
Missouri

Reporting Period:
From 7/1/2003 To 6/30/2004

Prevention Form P1
NUMBER OF PERSONS SERVED

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Persons served in Block Grant funded services include all persons served in prevention programs that receive all or part of their funding through the SAPT Block Grant.

AGE	TOTAL	SINGLE SERVICES	RECURRING SERVICES	RACE/ETHNICITY	TOTAL	SINGLE SERVICES	RECURRING SERVICES	GENDER	TOTAL	SINGLE SERVICES	RECURRING SERVICES
0-4	186	153	33	American Indian / Alaska Native	96	77	19	MALE	40168	17402	22766
5-11	35925	5534	30391	Asian	224	183	41	FEMALE	48267	23859	24408
12-14	22333	9450	12883	Black / African American	40762	4286	36476				
15-17	8418	6718	1700	Native Hawaiian / Other Pacific Islander	2	2	0				
18-20	1269	1081	188	White	43311	34142	9164				
21-24	1803	1690	113	More than one Race	984	777	207				
25-44	11670	10649	1021	Unknown	0	0	0				
45-64	6266	5453	813	Total	85379	39467	45907				
65+	565	533	32	Not Hispanic Or Latino	0	0	0				
				Hispanic Or Latino	1249	506	743				
Total	88435	41261	47174	Total	1249	506	743	Total	88435	41261	47174

State:	Reporting Period:
Missouri	From 7/1/2003 To 6/30/2004

PREVENTION FORM P2
NUMBER OF EVIDENCE-BASED PROGRAMS, PRACTICES, POLICIES, AND STRATEGIES

Programs include all prevention programs, practices, policies, and strategies that receive all or part of their funding through the SAPT Block Grant.

1.NREPP effective programs or practices (such as Project Northland or Life Skills) below.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total

2.NREPP conditionally-effective programs or practices (such as Reducing the Risk or FAN club) below.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total

3.NREPP emerging programs or practices (such as Focus on Kids or Brain Power) below.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total

4.NREPP programs or practices of interest.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total

5.Peer-reviewed journal-evidenced programs, practices, policies, and strategies.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total

6.Names and sources of other evidence-based programs, practices, policies, strategies; attach source and type of evidence.

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total

7.Names and sources of other non-evidence-based programs, practices, policies and strategies; attach additional information on the program, practice, policy or

Program Name / and Source	Universal Population	Selective Populations	Indicated Populations	Total
Selective programs	**0**	**11236**	**0**	**11236**
Universal programs	**70788**	**0**	**0**	**70788**
Indicated programs	**0**	**0**	**4646**	**4646**

TOTALS

GRAND TOTAL all programs	**86670**
Percent Evidence-Based (sections 1 - 6 above)	**0%**
Percent Non-Evidence-Based (section 7 above)	**100%**

Form P3

State:
Missouri

Reporting Period:	Participants:	Number of Programs:
From 7/1/2003 To 6/30/2004	Full Census	0

PREVENTION FORM P3
PERCEPTION OF RISK / HARM OF SUBSTANCE USE BY THOSE UNDER AGE 21

number and percent who responded “slight risk”, “moderate risk” or “great risk”
on pretest and posttest

CH Sc N = Number whose perception of risk/harm of substance use changed for the better (increased or remained stable) at posttest.
CH Sc % = Percent whose perception of risk/harm of substance use changed for the better (increased or remained stable) at posttest.

POPULATION		PRE TEST	POST TEST	CH SC
UNIVERSAL	**N**	**0**	**0**	**0**
	%	**0**	**0**	**0**
SELECTIVE	**N**	**0**	**0**	**0**
	%	**0**	**0**	**0**
INDICATED	**N**	**0**	**0**	**0**
	%	**0**	**0**	**0**
TOTAL	**N**	**0**	**0**	**0**
	%	**0**	**0**	**0**

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form P4

State:
Missouri

Reporting Period:	Participants:	Number of Programs:
From 7/1/2003 To 6/30/2004	Full Census	0

PREVENTION FORM P4
UNFAVORABLE ATTITUDES TOWARD SUBSTANCE USE BY THOSE UNDER AGE 21

number and percent who responded “somewhat disapprove” or “strongly disapprove”
on pretest and posttest

CH Sc N = Number whose unfavorable attitudes toward substance use changed for the better (increased or remained stable) at posttest.
CH Sc % = Percent whose unfavorable attitudes toward substance use changed for the better (increased or remained stable) at posttest.

POPULATION		PRE TEST	POST TEST	CH SC
UNIVERSAL	N	0	0	0
	%	0	0	0
SELECTIVE	N	0	0	0
	%	0	0	0
INDICATED	N	0	0	0
	%	0	0	0
TOTAL	N	0	0	0
	%	0	0	0

Form P5

State:	Reporting Period:	Participants:	Number of Programs:
Missouri	From 7/1/2003 To 6/30/2004	Full Census	0

PREVENTION FORM P5
USE OF SUBSTANCES DURING THE PAST 30 DAYS

Report the number and percent who responded
having used at least one or more times in the past 30 days

CH Sc N = Number whose use changed for the better (decreased or remained stable) at posttest.
CH Sc % = Percent whose use changed for the better (decreased or remained stable) at posttest.

DRUG		< 18 YEAR OLDS			18-20 YEAR OLDS			> 20 YEAR OLDS			TOTAL		
		PreTest	PostTest	CH SC	PreTest	PostTest	CH SC	PreTest	PostTest	CH SC	PreTest	PostTest	CH SC
Alcohol	N	0	0	0	0	0	0	0	0	0	0	0	0
	%	0	0	0	0	0	0	0	0	0	0	0	0
Tobacco	N	0	0	0	0	0	0	0	0	0	0	0	0
	%	0	0	0	0	0	0	0	0	0	0	0	0
Marijuana	N	0	0	0	0	0	0	0	0	0	0	0	0
	%	0	0	0	0	0	0	0	0	0	0	0	0
Cocaine/Crack	N	0	0	0	0	0	0	0	0	0	0	0	0
	%	0	0	0	0	0	0	0	0	0	0	0	0
Stimulants	N	0	0	0	0	0	0	0	0	0	0	0	0
	%	0	0	0	0	0	0	0	0	0	0	0	0
Inhalant	N	0	0	0	0	0	0	0	0	0	0	0	0
	%	0	0	0	0	0	0	0	0	0	0	0	0
Heroin	N	0	0	0	0	0	0	0	0	0	0	0	0
	%	0	0	0	0	0	0	0	0	0	0	0	0

Missouri

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1.-- The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FY 2003 compliance

During FY 2003 the Division of Alcohol and Drug Abuse (ADA) funded a continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are strategically placed throughout the state based on need assessments and availability of treatment services. Treatment was delivered by 34 primary treatment programs and 43 Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR).

The continuum of treatment services provided is briefly described below.

Detoxification

The first stage of treatment for many individuals will be detoxification from the alcohol or drugs to which they have become addicted. Detoxification is accomplished in a safe, supportive and monitored environment. Upon admission, the individual's need for detoxification services is assessed utilizing physician approved protocols by trained staff. This assessment will guide the person's placement into a level of care which can effectively meet the person's mental and physical detoxification needs.

Residential Rehabilitation

The most intensive level of treatment service, Residential Rehabilitation provides continuous supervision for personal safety, and recovery support is available anytime. Therapeutic activities are provided daily which includes assessment, group counseling and education, individual therapy, family therapy and recovery support activities. A minimum of 50 hours per week of therapeutic activities are provided.

During FY 2003 seven residential rehabilitation treatment programs participated in a pilot project conversion to Community Based Primary Treatment Programs. This program conversion changed the service delivery from a residential based model wherein everyone follows the same treatment schedule, to a continuum of treatment services model. In this new continuum of services model, a menu of treatment services are provided in one of three levels of care intensity patterned after the CSTAR continuum of care model described below in the CSTAR programs section of this report.

Outpatient Rehabilitation

Outpatient treatment is designed for individuals who present less severe symptoms of substance abuse and who have a home environment supportive of recovery. Also, individuals who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive support and treatment service.

CSTAR

The Comprehensive Substance Treatment and Rehabilitation Program (CSTAR) provides a continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical services which vary in duration and intensity depending on the assessed needs of the individual. Living arrangements and support services are

also individualized for each client. The continuum of care provided by CSTAR programs is divided into three levels described below. The person's assigned level of care at intake, their progression during treatment through less intensive levels of care and the person's discharge from treatment will be based upon the person's assessed needs and their progress towards treatment goals.

Community Based Primary Treatment with Residential Support (Level One)
The most intensive level of treatment service, Primary Treatment with residential support provides continuous supervision for client safety and recovery support is available anytime. Therapeutic activities are provided daily which includes group counseling and education, individual therapy and recovery support activities. A minimum of 50 hours per week of therapeutic activities are provided each week.

Community Based Primary Treatment without Residential Support
Primary Treatment without residential support provides an intense level of treatment five to seven days per week based on the assessed needs of the individual. A minimum of twenty-five hours of therapeutic activities are provided each week. The client lives at home, if the home environment is supportive of recovery, or in approved housing.

Intensive Outpatient Rehabilitation (Level Two)
Intensive Outpatient treatment is designed for individuals who have a home environment supportive of recovery and who present less severe symptoms of substance abuse. Also, individuals who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive an intermediate level of support and treatment service. Treatment services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are provided each week.

Supported Recovery (Level Three)
This level of care provides service on a regularly scheduled basis, usually weekly. Clients who are assessed not to need intense or structured clinical services may begin substance abuse treatment at this level on the continuum of care. Also, individuals who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive regular reinforcement of treatment principles. The frequency of services will be determined by the assessed clinical needs of the individual.

The CSTAR model was developed by ADA and is funded by Missouri's Medicaid program and ADA's purchase-of-service system. In the past, inpatient or residential treatment temporarily removed a person from the problem environment with little or no follow-up care. CSTAR focuses on providing a complete continuum of recovery services, including extended outpatient services, in the community and, where possible, close to the person's home.

CSTAR Women's Treatment Programs

Substance abuse affects women differently than men, both physically and psychologically. These programs address relevant therapeutic issues to women and their children. Pregnant women and women with children are the priority population for this program. Single women may also enter specialized women's CSTAR treatment programs. These programs provide the complete continuum of treatment services described above and housing supports tailored to the unique needs of women and children.

CSTAR Alt-Care Programs in Kansas City and St. Louis are specifically designed for female offenders. Probation and parole officers visit on-site to track and support women in treatment. These programs provide the complete continuum of treatment services described above and housing supports tailored to the unique needs of women and children.

CSTAR Adolescent Treatment Programs

Early intervention, comprehensive treatment, academic education, and aftercare are important in averting chronic abuse and accompanying problems that might otherwise follow a young person for a lifetime. The specially trained staffs of adolescent CSTAR programs provide substance abuse treatment services to adolescents 12 to 17 years of age. Treatment is targeted at relevant issues of adolescents and provided in settings that are both programmatically and physically separate from adult programs. These programs provide the complete continuum of treatment services described above and housing supports tailored to the unique needs adolescents.

CSTAR General Population Programs

These substance abuse treatment programs provide the complete continuum of treatment services described above and housing supports tailored to the unique needs of men and women Medicaid clients.

Opioid Treatment Programs

The Opioid Treatment Program (OTP) utilizes physician prescribed methadone to assist opiate addicted individuals to withdrawal from opiate drugs under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to facilitate the person developing appropriate life skills and a recovery life style. Missouri’s OTP complies with federal guidelines for such programs.

FY 2005 progress

During FY 2005 The Division of Alcohol and Drug Abuse (ADA) funded a continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are strategically placed throughout the state based on need assessments and availability of treatment services. Treatment was delivered by 34 Community Based Primary Treatment Programs and 43 Comprehensive Substance Treatment and Rehabilitation Programs (CSTAR).

A significant advance increasing the state's compliance with Goal # 1 occurred this reporting period. In 2004, seven primary treatment programs were converted to Community Based Primary Treatment programs offering a continuum of treatment services. Based on this successful pilot project, on April 1, 2005 twenty-two additional primary treatment programs were converted to Community Based Primary Treatment programs offering a continuum of treatment services. Now each treatment program ADA contracts with to provide substance abuse treatment services must provide or provide referral to a continuum of clinical service through levels of care varying in frequency and intensity to meet each individual's assessed needs.

In the past, primary treatment programs providing residential and outpatient treatment were not monitored by Clinical Utilization Review (CUR). Beginning in April 2005 with the conversion of these programs to Community Based Primary Treatment programs offering a continuum of treatment services, CUR is monitoring client placement and discharge decisions by these programs. CUR provides a monitoring and training function that serves to improve the implementation of the continuum of care provided.

In October 2004 the Access to Recovery (ATR) Grant was awarded to Missouri for three years. The purpose of the grant is to implement a statewide voucher system for adults that affords independent choice among an increased number of qualified service providers; provides recovery support services through traditional, non-traditional and faith-based organizations; expands the existing managed care system for proper control and monitoring; and measures outcomes in seven critical domains. The ATR Grant became operational in April of 2005 and will help to enhance all existing primary recovery programs to provide the full array of services including a continuum of care and trauma services. In some cases, ADA will issue Requests for Proposals to expand services into areas that are underserved and in others they will credential nontraditional and faith-based organizations to provide recovery support services in their communities. Recovery supports are intended to assist individuals in their recovery by keeping them engaged in treatment for longer periods of time and providing services such as spiritual enrichment, care coordination, child care, and work preparation to help them return to successful, productive lives in their community.

FY 2006 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to contract for a continuum of care of treatment services. Innovative and evidence based practices will continue to be reviewed for implementation in Missouri's substance abuse treatment continuum of care.

Certification Standard 9 CSR 30-3.130 Outpatient Treatment requires contracted substance abuse treatment programs to admit clients to specific levels of care and discharge persons according to specific criteria. This standard ensures implementation of a continuum of care of service for substance abuse treatment. The Division will continue the practice of contracted programs receiving a Certification Survey to determine and monitor their compliance with certification standards every three years.

Missouri

Goal #2: 20% for Primary Prevention

GOAL # 2.-- An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY2003 (Compliance)

Information:
The Missouri Division of Alcohol and Drug Abuse (ADA) supported the resource network involvement in health and prevention fairs, parades, and resource fairs as well as other numerous team events where information on alcohol, drugs, and tobacco use and abuse are disseminated to community members. Other national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3-D Month, and Alcohol Awareness Month were opportunities for Regional Support Centers and community coalitions to provide information about ATOD to community members. Support Center staff continued to make presentations to area civic groups at the local community levels. The community coalitions consisting of over 2000 members served as a venue to distribute information at the local level. ADA continued as a pilot state for the Minimum Data Set-3 (MDS-3). In order to support sustainability, the MDS-3 is administered through a state server. The prevention providers continued to receive MDS-3 training. The MDS-3 implementation continued to phase-in the prevention providers.

ADA contracted with the University of Missouri-Columbia to establish the Partners in Prevention (PIP) statewide coalition comprised of 12 Missouri public institutions of higher education, the Missouri Division of Liquor Control, and the Missouri Division of Highway Safety to collaboratively develop strategies for reducing and preventing high-risk drinking among Missouri's college students. The coalition encourages and nurtures collaboration among colleges and state agencies and creates partnerships that will result in systemic change in the environment. PIP publishes a quarterly newsletter titled "Journeys". The newsletter is sent to approximately 200 people across the state affiliated with colleges and universities, local agencies, and community teams.

ADA's Regional Alcohol and Drug Awareness Resource (RADAR) network located in Jefferson City, Kansas City, and St. Louis, made available current prevention information to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network supported local communities by providing information to community coalitions and teams about preventing teen alcohol, tobacco, and drug use and interventions for high risk groups. Several regional support centers published newsletters and produced websites that provided information to their community coalitions about community capacity building and important facts about alcohol, tobacco, and other drugs. They also showcased community success stories which help motivate communities with similar circumstances and problems. ADA's information dissemination strategy was implemented through multiple prevention providers such as: the three RADAR network sites, 11 Regional Support Centers, one Statewide Resource Center, the statewide University of Missouri sites, community coalitions to maximize opportunities including printed materials, media, and web-based sites to target the statewide population.

Education:
The Regional Support Centers provided training and technical assistance to members of community coalitions on the elements of effective coalitions. New team members are educated on facts regarding alcohol and substance abuse as they come on board. ADA awarded contracts totaling $600,000 for evidence-based community-based programming. CSAP Model Programs are being implemented through Boys and Girls Clubs, faith-based sites in Kansas City, and community sites in southwest and central Missouri. The curricula and their intended audiences are: Creating Lasting Connections, children 8-12 and their parents/guardians; All Stars for children aged 11-14 years; and Smart Moves for children aged 8-17 years. The curricula was provided to over 38,000 youth aged 8-17. ADA, through contractors, supported two-way communication and interaction between educator/facilitator and participant targeting specific groups within the general public such as retailers, teachers, civic organizations, parents, law enforcement, and youth.

Mobilization:
There were approximately 200 community coalitions registered with ADA. Sustainability and capacity building were the focus of the regional support centers in FFY2003. They surveyed community coalitions using the "Assessing Community Coalitions Assessment" developed by ACT Missouri. The survey helped coalitions identify their strengths and needs. This document guided the support centers in determining the types of training and technical assistance their coalitions needed in order to grow and develop. The assessment addressed the following areas: strategic thinking, broad diverse community membership, coalition leadership, diversified funding sources, training, and evaluation. Regional Support Centers worked with local coalitions to prioritize their goals based on the outcomes of this assessment. Local teams were encouraged to work with other prevention-related teams and task forces, including Caring Community partnerships, C.H.A.R.T. teams (Health Department), and Community Betterment and Development teams (Dept. of Economic Development).

Alternatives:
Community coalitions and community-based providers offered alternative prevention activities throughout the year. Resources to support alternative activities in the plans were made available through funding sources provided by ADA and through the consultant bank. The community coalitions were provided access to resources for the support of local team action plans through a consultant bank. The consultant bank provided support for outside consultants to assist teams in developing alternative activities, training and program development, or consultation and technical assistance related to specific problem areas. During FFY2003, 43 consultant bank requests from the teams were approved as a resource to alternative activities. ADA supported over 200 local community coalition activities which promoted healthy alternatives to alcohol, tobacco, and other drug use.

Missouri's targeted prevention program has two components: a high risk youth initiative and community-based prevention services for youth. The high-risk youth initiative provided a broad array of prevention programming in designated areas of the state.

Programming included traditional after school alternative activities, youth development activities and racial/ethnic cultural activities. Existing programming continued to implement the evaluation component to meet current evidenced-based principles for effective prevention. ADA funded five contracts totaling $600,000 to implement evidence-based community programs for youth. Significant among these awards was a $300,000 contract to Missouri Alliance of Boys and Girls Clubs to implement Smart Moves in 14 communities in all areas of the state.

Environmental (Social Policy):
Information on social policy issues was provided to teams via the "ACTION" newsletter of ACT Missouri. The network of community coalitions were involved at the local district levels and at the state level (by testifying before legislative committees). Community team members were involved in legislation related to zero tolerance for youth alcohol and driving, increased excise taxes on alcoholic beverages, legalization of marijuana for medical use, and methamphetamine production. Community teams also acted as change agents by educating teens about alcohol use and developing strategies for changing both laws and taxation policies related to alcohol. These efforts were in conjunction with ACT Missouri's Robert Wood Johnson Underage Alcohol Use grant.

ADA continued to participate on the Perinatal Substance Abuse Advisory Committee. This state-wide interagency collaboration is committed to ensuring the health and welfare of pregnant and postpartum women, children and their families. The Department of Mental Health's Director of Prevention was the lead writer of a grant that will enable Missouri to develop and implement a comprehensive prevention effort, encompassing multiple risk domains and utilizing a range of preventive interventions in order to increase public awareness of the risks associated with any level of drinking while pregnant and effect an absolute reduction in the rate of alcohol-exposed births and effect changes in public policy in order to enhance coordination of services planned for and delivered to this population by various state agencies.

Missouri Partners in Prevention (PIP) is a coalition comprised of representatives from each of Missouri's twelve (12) public universities. PIP's goal is to reduce binge drinking among Missouri's college students by three percentage points from FFY2000 baseline data. The proposed strategies are dissemination of information, prevention education, alternative activities, community based processes, environmental approaches, and problem identification and referral. The coordinator of Partners in Prevention met with the Law Enforcement Steering Committee on a regular basis. Social-norming campaigns continued to be a priority on the college campuses.

Problem Identification and Referral:
ADA continued to identify and respond to substance abuse-related problems of young children of women who are in treatment for substance abuse. ADA also continued to respond to the needs of the deaf and hearing impaired population in general and youth in particular through operation of a "warm-line" for problem identification and referral. Problem identification and referral is a component of the SPIRIT initiative. The initiative

began during the 2002-2003 school year. The first year of the initiative developed a tracking system for problem identification and referral and continued during FFY2003.

FFY2005 (Progress)

Information:
The Missouri Division of Alcohol and Drug Abuse (ADA) continued to support Regional Support Centers in providing information on legislative updates, team leaders meetings, grant and funding information, and conference and workshop information to community coalitions. Merchant education materials are developed yearly and distributed to the Regional Support Centers for dissemination during the annual tobacco merchant education campaign. A merchant training manual was developed based on the U.S. Department of Health and Human Service's "Best Practices for Responsible Retailing" Conference Edition Draft. The document focused on helping retailers with the comprehensive training of sales personnel. Approximately 6,100 tobacco retailers were notified through a letter that this document was available for their use. Regional Support Centers developed a training plan based on this document and during the campaign informed retailers of the availability of technical assistance and training for their employees. Several support centers have partnered with the Division of Liquor Control and have provided training to vendors in their region.

ADA's RADAR network continued to make available current prevention information to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network supported local communities by providing information to community coalitions and teams about preventing teen alcohol, tobacco, and drug use and interventions for high risk groups. ADA continued a radio and television counter-marketing campaign focused on underage drinking. ADA developed television and radio ads targeting teenagers and radio ads targeting parents of children and teenagers. Also, an ad targeting parents was licensed from FACE Resources, Training & Action on Alcohol Issues. The Public Service Announcements (PSA) created from the "Alcohol, Is It Worth It?" campaign were recognized as a Telly Award recipient. The campaign served as a venue for statewide information distribution. ADA also continued a prevention website for the public. Risk and protective factors are utilized and examples of focus topics include: alcohol, marijuana, underage drinking, suicide, and Fetal Alcohol Syndrome Disorder. The website address is www.MissouriPrevention.org. ADA continued support for information dissemination through multiple prevention providers such as: three RADAR network sites, 11 Regional Support Centers, one Statewide Resource Center, the statewide University of Missouri sites, community coalitions, printed materials, media, and ADA's website.

Education:
ADA continued implementation of a State Incentive Planning Grant--the Governor's Substance Abuse Prevention Initiative. Under the grant, a Governor's Advisory Committee was established and planning and special population studies initiated. ADA, in collaboration with the Department of Public Safety, and Division of Alcohol and Tobacco Control, developed a curriculum focused on responsible retail practices and ID checking strategies. Retail employees were trained on an "as requested" basis. In addition, ADA worked together with the Greene County Prosecutor's Office to provide

tobacco education to youth charged with tobacco possession. The Tobacco Education Project supports cessation and promotes abstinence from tobacco.
The Missouri SPIRIT program is progressing. District and contractor staff taught evidence based curricula to over 4,500 students in 5 districts. The curricula being taught include: Positive Action for Living, Peace Builders, Life Skills Training, Positive Action, Reconnecting Youth, and Second Step.

The Missouri SPIRIT evaluation team lead by Carol Evans of the Missouri Institute of Mental Health developed protocols, instruments, and procedures for assessing implementation and impact of Missouri SPIRIT. The team conducted meetings with each district and contractor. Consent and assent forms were developed, approved, and distributed; districts agreed to make individual student data (for example attendance records and achievement test scores) available to the evaluation team; and a data collection manual was developed and distributed. Fidelity instruments were reviewed and revised to obtain information from teachers/providers pertaining to curricula dosage and modifications to program materials.

ADA continued work towards a prevention newsletter and web site during the fiscal year. ADA continued to provide training and technical assistance to community coalitions through the Missouri Substance Abuse Prevention Resources Network on the elements of effective coalitions. The Statewide Resource Center conducted its annual conference in St. Louis in July 2004. The conference, open to community members statewide, featured sessions such as making healthy connections between life and work, focusing on the importance of results and measurable outcomes, locating hidden sources of grant funding, writing persuasive successful grant applications, and learning to better articulate the visions we share.

Mobilization:
The Regional Support Centers continued to assist local teams, task forces and coalitions in developing the skills necessary for effective functioning. The support centers used a community assessment tool to survey their community coalitions in their service areas. This tool identified areas that the coalitions need to work on to become more effective in making changes in their communities. The number of coalitions has remained consistent at approximately 200. In addition to those that are youth-based or youth-focused, there are culturally specific coalitions for Native Americans, Hispanics, and deaf and hearing impaired populations.

Alternatives:
In addition to the support for local community coalition activities which promote healthy alternatives to alcohol, tobacco, and other drug use, ADA is moving toward greater measurement of results and the implementation of best practice prevention programs. Community coalitions provided alternative prevention activities throughout the year based on the annual community team action plan. A consultant bank provided support for outside consultants to assist teams in developing alternative activities, training and program development, or consultation and technical assistance related to specific problem areas. During FFY 2005, over 40 consultant bank requests from the teams

were approved as a resource to alternative activities. Another resource for communities was provided through mini-grants. ADA distributed approximately 63 awards ranging from $5,000 to $10,000 under the categories of capacity building, model programs, and community norms. The average award was approximately $6,400.

ADA continued support of targeted prevention programming for high-risk youth and community-based programming. The programming includes traditional after-school alternative activities, youth development activities, and racial/ethnic cultural activities. ADA also supported five contracts totaling $600,000 to implement evidence-based community programs for youth. This reflects the state's commitment to develop an evidence-based prevention services system. Significant among these awards was a $300,000 contract to Missouri Alliance of Boys and Girls Clubs to implement Smart Moves in 14 communities in all areas of the state.

Environmental (Social Policy):
"Alcohol, Is It Worth It?" is a comprehensive, broadcast media ad campaign targeting non-urban high school-aged youth, parents, and other adults. The campaign consisted of eight different, themed ads (five television and three radio) plus one television PSA targeting late teenage party-goers. The boys and girls campaign used paid placement on prime time television and radio with high youth viewer/listener numbers, including shows like "Survivor," "Fear Factor," and "Everwood" and Top 40 and Hot Country radio stations. The campaign ran from February to May, 2005. However, all stations are able to run the ads as PSAs beyond the campaign period. The campaign primarily targets youth and adults outside of the St. Louis and Kansas City metropolitan areas, because that is where survey data indicates underage alcohol use is highest. The campaign was recognized as a Telly Award recipient.

The members of Missouri Partners in Prevention (PIP) met on a monthly basis to discuss issues and concerns regarding alcohol use/abuse by students at their local university. PIP is housed in the Wellness Resource Center/ADAPT at the University of Missouri-Columbia. Each of the member universities conducted the CORE Institute Alcohol and Drug Survey. The survey was administered to a random sample of five percent of each school's population. The CORE was administered between February-May, 2005. The statewide summary indicates that alcohol use among these schools is high. About 48% of students reported engaging in binge drinking behavior at least once within a two-week period. Two-thirds (66%) of Missouri college students stated that they used alcohol before the age of 18.

Through its small grants program (formerly called "mini-grants") ADA supported environmental activities. The three categories available for support in FFY 2005 were Capacity Building, Sustainability, and Environmental Strategies. Three of the coalitions implementing environmental strategies will also be implementing Communities Mobilizing for Change on Alcohol.

Problem Identification and Referral:
ADA provided age-appropriate, developmentally based support services for children to break the cycle of inter-generation substance abuse. Screenings were conducted for each child under age 12 whose mother was admitted for residential treatment for substance abuse. The record documents the child's developmental, physical, emotional, social, educational, and family background and current status. If indicated by the screening, a qualified staff member completed an assessment. The assessment determined the appropriate therapeutic services to guide the development of an individualized treatment plan.

All programs providing specialized services to women and children addressed therapeutic issues relevant to children. Services were provided by staff who are qualified in child development, and who are knowledgeable about substance abuse prevention. Age appropriate activities, training, and guidance were offered on the following goals: building self-esteem; learning to identify and express feelings; building positive family relationships; developing decision making skills; understanding chemical dependency and its effects on the family; learning and practicing nonviolent ways to resolve conflict; learning safety practices such as sexual abuse prevention; and addressing developmental needs. These activities were provided to enhance the social and family functioning and increase resilience.

ADA continued its support for problem identification through the SPIRIT initiative. The preliminary results from the data collection are still under review. The Division continued to respond to the needs of the deaf and hearing impaired population in general, and youth in particular, through operation of a "warm-line" for problem identification and referral.

FFY 2006 (Intended Use)

Information:
The Missouri Division of Alcohol and Drug Abuse (ADA) will continue supporting the Regional Support Centers in providing information on legislative updates, team leaders meetings, grant and funding information, and conference and workshop information to community coalitions. Plans are to continue developing information pertaining to the state law and retailer training for merchants who sell tobacco products. ADA's RADAR network will continue to make available current prevention information to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network will continue to support local communities by providing information to community coalitions and teams about preventing teen alcohol, tobacco, and drug use and interventions for high risk groups.

ADA will continue supporting information dissemination through multiple prevention providers such as: the three RADAR network sites, 11 Regional Support Centers, one Statewide Resource Center, the statewide University of Missouri sites, community coalitions, printed materials, media, and web-based sites that target the statewide population. The "Alcohol, Is It Worth It?" and "Healthy Bodies, Safe Communities" underage drinking counter-marketing campaigns will continue using new content.

Education:
ADA will continue to support Missouri SPIRIT, which is entering its third year of implementation. All districts are enthusiastic about continuing to participate in the program and will continue to submit anecdotal reports of changes in behavior in the classroom. ADA will continue support for the implementation of evidence-based curricula with youth and families. ADA will continue to support training and technical assistance activities for members of local coalitions; training and technical assistance will focus on developing the elements of effective coalitions. In addition, ADA will continue to support educational activities directed toward reduction of underage and high-risk drinking by students on Missouri's 12 state-supported college campuses.

Mobilization:
The Regional Support Centers will continue to assist local teams, task forces and coalitions in developing the skills necessary for effective functioning. The support centers will continue using a new annual training and technical assistance plan in FFY 2006. This plan includes the coalition training needs self assessment, coalition assessment worksheet, team work plan, summary of needs, goals and objectives, team monthly service strategies report, team monthly service report, and a support center monthly report. ADA will continue to develop the knowledge and skills needed concerning risk and protective factors and provide accountability through research-based best practice models. Finally, ADA will support community mobilization activities addressing methamphetamine manufacture and use in northeastern Missouri.

Alternatives:
Goals remain the same for FFY 2006. Community coalitions are encouraged to provide alternative activities and can apply for a regional development fund to assist with those efforts. The support centers are encouraged to move coalitions from alternative activities to education and eventually to implementation of best practice prevention programs. Limited funds will be available for coalitions who conduct only alternative activities without the other prevention strategies. ADA will continue to fund targeted prevention programming for high-risk youth and community-based programming. The programming includes traditional after-school alternative activities, youth development activities, and racial/ethnic cultural activities. ADA will continue to fund five contracts totaling $600,000 to implement evidence-based community programs for youth. This funding reflects the state's commitment to develop an evidence-based prevention services system. Significant among these awards is a $300,000 contract to Missouri Alliance of Boys and Girls Clubs to implement Smart Moves in 14 communities in all areas of the state.

Environmental (Social Policy):
A large portion of ADA's environmental strategies programming and activities will be supported by funding from the U.S. Office of Juvenile Justice and Delinquency Prevention through the Enforcing Underage Drinking Laws (EUDL) grant and a EUDL Community Trials Initiative discretionary grant. Community coalitions will continue to receive information on environmental strategies through the Statewide Resource Center newsletter. Missouri Partners in Prevention (PIP) goals remain the same as in FFY2005. The members of PIP will continue meeting on a monthly basis to discuss issues and concerns regarding alcohol use/abuse by students at their local universities. PIP is housed in the Wellness Resource Center/ADAPT at the University of Missouri-Columbia. Plans for running "Alcohol, Is It Worth It?" are being made for FFY2006. The environmental strategies category will continue to be part of the small grants program.

Problem Identification and Referral:
ADA will continue to identify and respond to substance abuse related problems of young children with mothers receiving treatment for substance abuse. As ADA moves toward best practice models, the appropriate programs will be reviewed to determine viability. As a partner with the Missouri Department of Health and Senior Services for a Fetal Alcohol Syndrome Disorder prevention grant from the Centers for Disease Control and Prevention, ADA will screen children of mothers receiving substance abuse treatment. Additionally, Motivational Interviewing techniques and the Personal Choices model program will be implemented. ADA will continue to support the problem identification and referral component of the SPIRIT initiative and respond to the needs of the deaf and hearing impaired population.

Missouri

Goal #3: Pregnant Women Services

GOAL # 3.-- An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FY 2003 Compliance

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA) has maintained the delivery of specialized CSTAR services to pregnant women and mothers with dependent children. Missouri continues to offer CSTAR services to women and children suffering from the effects of substance abuse. CSTAR comprehensive programs allow women and their children to receive multiple levels of care depending on assessed need. CSTAR programs are available in each region of the state. ADA has maintained certification standards which require substance abuse treatment services for pregnant or postpartum women or women with custody of children be first priority. During FY 2003, 369 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR Certification Standards and contract requirements. Nursing services are available at the program site and a community support worker assists the client with necessary medical referrals and scheduling of appointments. Childcare is provided on-site or the program makes arrangements for child care at all CSTAR programs specializing in treatment of women and children. Contract monitoring and certification surveys include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care and children are receiving safe and appropriate childcare. Monitoring schedules are current, and programs are in compliance.

FY 2005 Progress

The Division of Alcohol and Drug Abuse continues to provide specialized CSTAR services for pregnant women and women with dependent children. During FY 2004, 400 pregnant women were admitted to substance abuse treatment services. This year additional Medicaid money is available for the treatment of pregnant women. Program staff provided orientation sessions to medical facility staff about the availability and types of treatment services available to pregnant women and their children. Evidence-based treatment to increase appropriate coping with trauma skills is being implemented in these programs.

FY 2006 Intended Use

The Division of Alcohol and Drug Abuse will continue to provide specialized CSTAR services for pregnant women and women with dependent children. The implementation of evidence-based practices will continue to be a priority as well as quality assurance monitoring of this treatment. The monitoring of programs will continue to be completed annually. An annual Safety and Basic Assurance Review will be completed for each agency that includes a review of contract, certification and billing requirements. A certification survey will be completed every three years for each agency.

Missouri

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2003) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2003. In a narrative of up to two pages, describe these funded projects.

Attachment B

Treatment for women in the State of Missouri has been enhanced over the past fifteen years, due, in part, to the block grant funds. Missouri's Department of Mental Health's Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women only in gender integrated programs to developing programs designed specifically for women and their children. Twelve contracts have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children and offer multiple treatment site locations across the state. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. The dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2003 block grant funds for at least a 5% set aside has been exceeded.

Urban hospitals in St. Louis and Kansas City noted the increase in drug-affected children in the late 1980's. By 1988, the number of impaired infants brought about an organized request to ADA to begin treating pregnant and postpartum women and their children. Concurrently, the CSTAR program was being developed to meet the needs of this specific group of women and their children. Women are defined as requiring treatment when their use of alcohol and other drugs has caused dysfunction in any area of their lives. By offering a continuum of care, CSTAR is suited to match the level of care to the assessed needs of the woman and her children. This continuum of care is described below.

Community-based Primary Treatment
This is the most structured and intensive treatment in the continuum of care, and is provided in a trauma sensitive environment. Services are provided five to seven days per week. Treatment is provided in a menu of services referred to as Day Treatment, which includes up to nine hours per day of group and individual counseling, group education, and structured recovery support activities. Also available at this level of care are community support, family therapy, coping with trauma skills, residential support and day care for dependent children. Age appropriate assessment and co-dependence counseling is provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Intensive Outpatient Rehabilitation
This treatment is designed for women who have a home environment supportive of recovery or are living in approved housing and present less severe symptoms of substance abuse. Women who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive an intermediate level of support and treatment service. Treatment services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are provided each week. Treatment is provided in a trauma sensitive environment and consists of a menu of services including; group counseling and education, individual counseling, community support, family therapy, coping with trauma skills and day care for dependent children. Age appropriate assessment and co-dependence counseling is provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Supported Recovery
This level of care provides service on a regularly scheduled basis, usually weekly. Women who are assessed not to need intense or structured clinical services may begin substance abuse treatment at this level on the continuum of care. Women who have completed a more intense

level of treatment are transitioned into this level of care to provide opportunities to interact within their families and community while continuing to receive regular reinforcement of treatment principles. The frequency of services will be determined by the assessed clinical needs of the woman. Treatment is provided in a trauma sensitive environment and consists of a menu of services including; group counseling and education, individual counseling, community support, family therapy, coping with trauma skills and day care for dependent children. Age appropriate assessment and co-dependence counseling is provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Women are offered group education on a wide array of topics such as drug education, communication skills, anger management, coping with trauma skills, and relapse prevention. Group counseling is offered to allow clients to explore emotional issues and work towards healthy relationships and lifestyles. Individual counseling allows for further exploration and working towards specified individualized treatment goals.

Child care is provided at all levels of CSTAR programming for women while they attend treatment sessions. State Certification Standards require each program to be a licensed day care facility for children. A Child Therapist is required on each program staff to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs. Codependency counseling and family therapy are provided for all persons identified with a need for these services.

Women who are homeless when they enter treatment may receive housing assistance from ADA while participating actively in treatment. Community housing is time limited and intended as a bridge to other, long term housing arrangements. The stipend for community housing is a maximum of $500.00 and can be used to pay rent, initial deposits, utilities and local telephone service.

All women and children who enter treatment are provided health screenings to identify health deficits or needs for medical intervention. Within the CSTAR programs, registered nurses are on duty to assist mothers and their children to achieve health goals. The nurses on-site at each facility offer medical services, referral, and education for all children and families. Each child is required to have a current physical exam and current immunizations. The Community Support Workers assist the clients in arranging medical appointments and obtaining transportation. Close associations with local health clinics, hospitals and doctors provide prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. All CSTAR programs conduct an HIV/STD/TB risk assessment for all clients at admission. Pre and post test counseling for HIV/AIDS, STD and TB are available on site or by referral at all CSTAR women's programs. This innovative healthcare provision was a result of the FFY 1997 mandate to increase and improve services for women.

Dramatic results have occurred due to the provision of treatment services specifically designed for women. In FY2005 over 6751 women and children were treated in the CSTAR women and children programs. In FY2005, 88 out of 91 babies born to women in CSTAR programs were born drug free. In addition, 102 children were returned to their mother's custody from the Division of Family Services because their mothers had regained their ability to manage healthy families and live productive lives. The emotional rewards and cost savings from these program measures alone support the cost effectiveness of continuing specific substance abuse treatment for women and children. The State is moving towards a standardized outcome-based system of monitoring client improvement on numerous domains. Implementation of evidence-based practices to treat this special needs population and quality improvement are on going goals.

Missouri

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2003 block grant and/or State funds?

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2003 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B Continued

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The capacity of CSTAR programs in all three levels are limited by the amount of general revenue and Medicaid dollars available. However, the residential component at facilities is limited to 16 beds for the primary clients and 10 beds for children. Housing can be made available for families that are homeless or alienated from their families of origin. All the women's facilities have access to supportive housing money, and therefore can offer additional safe housing options.

The number of clients served in all three levels in FFY 2003 at the women's treatment programs by agency was: BASIC - 640, Bridgeway Counseling Services, Inc. - 1,139, Family Counseling Center of Missouri, Inc. - 752, Family Counseling Center, Inc. - 514, Family Self-help Center - 526, Hannibal Council on Alcohol and Drug Abuse - 523 Alternative Opportunities - 700, New Beginnings Alt-Care - 490 Queen of Peace Center - 1,026, Renaissance West, Inc. - 609, and Research Mental Health Services – 793, Research Mental Health Services Alt-Care - 445.
Included is a list of all women's and children's CSTAR programs in Missouri including the Substate Planning Area (SPA) and the National Federal Registry (NFR) ID.

BASIC (Black Alcohol/Drug Service Information Center)
Locust, Suite 800
St. Louis, MO 63103
Allocated funds FY 2003 $750,226
SPA: Eastern Region
NFR ID: MO100880

Bridgeway Counseling Services
307 North Main
St. Charles, MO 63301
Allocated funds FY 2003 $984,977
SPA: Eastern Region
NFR ID: MO101136, MO101458

Family Counseling Center of Missouri, Inc.
McCambridge Center for Women
201 North Garth
Columbia, MO 65203
Allocated funds FY 2003 $838,629
SPA: Central Region
NFR ID: MO101003

Family Counseling Center, Inc.
Cape Girardeau CSTAR
20 South Sprigg, Suite #2
Cape Girardeau, MO 63701
Allocated funds FY 2003 $858,619
SPA: Southeastern Region
NFR ID: MO101123

Family Self-Help Center
Lafayette House Serenity Program
Box 1765, 1809 Connor Avenue
Joplin, MO 64802
Allocated funds FY 2003 $687,991
SPA: Southwestern Region
NFR ID: MO101029

Hannibal Council on Alcohol and Drug Abuse
146 Communications Drive
Hannibal, MO 63401
Allocated funds FY 2003 $763,464
SPA: Northern Region
NFR ID: MO101219

Alternative Opportunities
Carol Jones Recovery Center for Women
2411 West Catalpa Street
Springfield, MO 65807
Allocated funds FY 2003 $302,944
SPA: Southwestern Region
NFR ID: MO903879

New Beginnings Alt-Care
3901 N Union Blvd, Suite 101
St. Louis, MO 63115-1130
Allocated funds FY 2003 $875,500
SPA: Eastern Region
NFR ID: MO102092

Queen of Peace Center
325 North Newstead
St. Louis, MO 63108
Allocated funds FY 2003 $952,363
SPA: Eastern Region
NFR ID: MO100591

Renaissance West, Inc.
5840 Swope Parkway
Kansas City, MO 64127
Allocated funds FY 2003 $929,753
SPA: Western Region
NFR ID: MO100898

Research Mental Health Services North Star Recovery Services
(Two programs; Alt-Care women's Correctional and a Women and Children Program)
2801 Wyandotte
Kansas City, MO 64108
Allocated funds FY 2003 Women and Children $989,405
Allocated funds FY 2003 Alt-Care Women's Correctional $875,500
SPA: Western Region
NFR ID: MO101094

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY2003 block grant funds?

Treatment for women in the State of Missouri has expanded remarkably over the past fifteen years, due in part to the block grant funds. Missouri's Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women in gender integrated programs to developing programs designed specifically for women and their children. Twelve contracts with multiple treatment site locations have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children in Missouri. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The women's dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FFY 2003 block grant funds for at least a 5% set aside has been exceeded.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The specialized programs to meet the needs of pregnant women and women with dependent children are monitored on a regular basis. All CSTAR treatment programs receive a site Certification Survey annually from a team of treatment certification specialists. The programs are reviewed with a set of comprehensive CSTAR standards. In addition to this annual survey, ADA staff performs Contract Compliance Audits annually and make technical assistance visits when necessary.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The State uses data reported by the contract providers on a routine basis for monitoring the treatment capacity and utilization by women. The Department of Mental Health maintains a central data system that identifies, among other data, the services provided, number of clients and demographics (including pregnancy at admission) of clients. Requests for treatment by women have increased substantially over the past fifteen years. In 2000, a Placement of Expanded Treatment Services document was developed to assist ADA in placement of new CSTAR – Women and Children's programs as funds became available. Through these mechanisms, areas of the state that require additional treatment resources are identified and new programs are planned.

5. What did the State do with FY 2003 block grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Missouri has been a leader in providing quality substance abuse treatment services to women and their children. ADA has 12 contracts providing CSTAR programs specifically for women at multiple locations. There are an increasing number of women served in state funded programs. The number of women and children treated in CSTAR Programs has increased from 2,548 in FY1995 to 8157 in FFY2003.

Missouri

Goal #4: IVDU Services

GOAL # 4.-- An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FY 2003 (Compliance)

Treatment providers were required to admit persons who abused injecting drugs within the past thirty days or were in imminent danger of relapse. Provider contracts require these persons be admitted within 14 days of request. The CTRAC information system designed and maintained by the Missouri Department of Mental Health has a registration option of screening/waiting rather than admission. The Division of Alcohol and Drug Abuse (ADA) encourages each provider to maintain contact with those clients on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have developed informal telephone communications to refer clients to other programs when they are unable to meet the needs of those clients seeking treatment. This has proven to be an effective process. ADA includes block grant intravenous drug abuser treatment requirements in its awarded contracts. Compliance has been consistently monitored with the Certification Survey process, and annual Contract Compliance Audits now referred to as Safety and Basic Assurance Reviews.

FFY 2005 (Progress)

The Division of Alcohol and Drug Abuse (ADA) has utilized its Area Treatment Coordinators to monitor provider operations and ensure contact compliance on an annual basis utilizing the Block Grant Compliance Checklist during the annual Safety and Basic Assurance Review. Regional staff has been trained to understand contract requirements and to apply them to substance abuse treatment programs. Agencies found to be out of compliance were identified and an action plan to achieve contract compliance was required. Technical Assistance consultation and focused compliance reviews were applied to those treatment agencies serving large numbers of intravenous drug users to ensure consistent compliance and provision of high quality of service to the high risk intravenous substance abuser clientele. Provider staff participated in collaborative model cross-training with the Department of Health and Senior Services to provide them with screening and risk assessment training to encourage their utilization of effective targeted risk reduction intervention strategies to address the high risk behaviors of intravenous drug abusers.

FFY 2006 (Intended Use)

Annual Safety and Basic Assurance Reviews conducted by regional staff will continue to monitor treatment agency compliance with block grant requirements for intravenous substance abusers. Agencies out of compliance will be identified and an action plan to bring the contracted provider into compliance will be required. Contract compliance monitoring will continue to include consistent provider application of effective screening and intervention techniques to reduce the risk of infectious and blood borne communicable diseases which include TB, HIV/AIDS, STDs and Hepatitis.

The Division of Alcohol and Drug Abuse (ADA) contracted providers will be encouraged to continue their active participation in regional cross-training with the Department of Health and Senior Services to learn to apply the most effective risk reduction intervention strategies for this high risk IV drug using population. Hepatitis risk reduction will be paired with HIV risk reduction to encourage clientele to practice health risk reduction to encourage successful recovery efforts.

Special consultation, technical assistance, and consistent review will continue to be applied to those treatment agencies serving large numbers of intravenous drug users to ensure compliance with block grant requirements and quality in their service provision.

Missouri

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix)

For the fiscal year three years prior (FY 2003) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. What did the State do to ensure compliance with 42 U.S.C. 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FY 2003 SAPT Block Grant funds (See 45 C.F.R. 96.126(a))?

3. What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug (See 45 C.F.R. 96.135(a)(6))?

4. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2003 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

5. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

6. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

1. Intravenous drug abusers include all substance abusing persons whose primary, secondary, or tertiary route of administration is by needle, whether intravenously or intramuscularly.

2. During FY 2003, Missouri designated funds exclusively for intravenous drug abuse prevention and treatment services, and contracted with specialized programs to provide those services. Two opioid treatment programs provided services including prescription and dispensing of methadone, combined with appropriate medical and recovery services to decrease the morbidity of withdrawal from heroin or other opioid drugs. Comprehensive care programs treated intravenous drug abusers in a continuum of care including; Community Based Primary Treatment, Intensive Outpatient and Supportive Recovery. The specialized opioid treatment programs are located in the urban areas of Kansas City and St. Louis. However, intravenous drug abusers were admitted to and treated in other Division of Alcohol and Drug Abuse (ADA)-funded substance abuse treatment programs throughout the state.

3. Treatment providers were prohibited by contract from distributing needles for injection of any illegal drug. The prohibition also included distribution of bleach for the purpose of cleaning needles for such injection. Compliance was monitored by regional staff conducting program site reviews. Monitoring did not uncover any violation or failure to comply with these requirements.

4. Throughout FFY 2003 all providers operated at or near capacity, with all agencies maintaining at least 90 percent capacity. Agencies not at capacity were quickly filled with referrals from waiting lists from other treatment programs.

5. Treatment providers were required to admit persons who abused injecting drugs within the past thirty days or who were in imminent danger of relapse. Provider contracts require these persons be admitted within 14 days of request. If at capacity, programs will make referrals to other resources in the community, for example, private pay opioid treatment programs or detoxification programs. The CTRAC information system designed and maintained by the Missouri Department of Mental Health has a registration option of screening/waiting rather than admission. ADA encourages each provider to maintain contact with those clients on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have developed informal telephone communications to refer clients to other programs when they are unable to meet the needs of those clients seeking treatment. This has proven to be an effective process. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during Certification Surveys and Safety and Basic Assurance Reviews.

6. In FFY 2003, ADA contracted with community-based providers in the Kansas City and St. Louis areas for needs assessment, public information through the media, and one-on-one intervention with identified intravenous drug abusers.

These outreach programs included: selecting, training, and supervising outreach workers who are indigenous to high-risk neighborhoods and target populations. Outreach staff searched for at-risk users on street corners and in vacant buildings. Classroom and community presentations were also provided. Available treatment services were publicized through agencies and organizations that have more regular and extensive contact with the target population. Special populations targeted included prostitutes (through county and municipal courts) and probation/parole clients with a history of intravenous drug abuse. Out reach activities promoted awareness among injecting abusers about the relationship between injection and communicable diseases such as HIV. Information on ways to prevent HIV transmission was presented and entry into treatment was encouraged.

Missouri

Attachment D: Program Compliance Monitoring

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2004) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

· A description of the strategies developed by the State for monitoring compliance with each of the sections identified below:

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a)
   (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

2. Tuberculosis Services 42 U.S.C. 300x-24(a)
   (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(viii)); and

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b)
   (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

· A description of the problems identified and corrective actions taken.

1. Notification of Reaching Capacity

All treatment agencies in Missouri continue to remain at or near capacity. Monitoring procedures are in place to assist clients in accessing treatment as quickly as possible. Agency activity levels are monitored at the regional level through the Regional Administrators and Area Treatment Coordinators. The CTRAC information system designed and maintained by the Missouri Department of Mental Health (DMH) has a registration option of screening/waiting rather than admission. The Division of Alcohol and Drug Abuse (ADA) encourages each provider to maintain contact with those clients on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have developed informal telephone communications to refer clients to other programs when they are unable to meet the needs of those clients seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating treatment services throughout the state. ADA has a toll-free number advertised for consumers to call for referrals. Regional staff receives the calls and make referrals to treatment programs in the consumer's area.

2. Tuberculosis Services

ADA collaborated with the Missouri Department of Health and Senior Services (DHSS) to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all clients entering treatment programs. Services include counseling about tuberculosis, health risks, and risks of transmission; testing to determine whether the individual has been infected with mycobacterial tuberculosis to determine the appropriate form of treatment for the individual; and providing for or referring individuals infected by tuberculosis for appropriate medical evaluation and treatment.

All drug and alcohol treatment facilities are required by contract to provide for tuberculosis testing. Some facilities provide testing on site while others refer clients to the local health department. The treatment facilities have established and maintained collaborative relationships with their local health departments. Clients have access to testing at any time during their treatment. Agencies may not deny access to treatment based on a positive test result providing the individual does not have active disease. Providers of treatment are required by contract to make appropriate referrals for persons seeking services who are not admitted to their program. Treatment programs can collaborate with the local health department for treatment staff to observe individuals taking preventive medicine for a positive tuberculosis skin test.

If an agency has difficulty finding services or has concerns about referring someone with positive tuberculosis test results, a treatment specialist from ADA will be consulted. The treatment specialist would then assess the needs of the client, advise agency staff of procedures and protocols and if necessary seek assistance from the DHSS, Bureau of Tuberculosis Control in determining appropriate services.

Training and education opportunities are available to provider staff through the DMH and through local health departments. ADA's treatment specialists, Regional Administrators, and Area Treatment Coordinators will continue to work with treatment providers and county health departments to maintain and improve tuberculosis services. Through site Certification Surveys, Safety and Basic Assurance Reviews, and technical assistance visits, ADA will monitor tuberculosis services including; screening, referral, testing procedure, counseling, and confidentiality. Safety and Basic Assurance Reviews are conducted once a year and technical assistance visits as needed.

The infection control recommendations and protocols include but are not limited to the following procedures: screening of patients, identification of those individuals who are at high-risk of becoming infected, and meeting all state reporting requirements while adhering to federal and state confidentiality requirements.

No problems were identified and therefore no corrective actions were taken.

3. Treatment Services for Pregnant Women

Through contractual requirement, all service providers that specialize in women's treatment must give priority to pregnant women seeking admission to treatment. Also CSTAR certification standards (9 CSR 30-3.190 Specialized Program for Women and Children) state that "Priority shall be given to women who are pregnant or postpartum" and that "The program shall engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria." Compliance is monitored through Certification Surveys, and annual Safety and Basic Assurance Reviews at each agency. No problems were identified and therefore no corrective actions were taken.

Missouri

Goal #5: TB Services

GOAL # 5.-- An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY 2003 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Missouri Department of Health and Senior Services to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all clients entering treatment programs.

FFY 2005 (Progress)

Contracted treatment providers have been required to make tuberculosis skin testing available to all clients in their programs. Contracted treatment providers are required to maintain effective linkages with local health departments to assist their staff with client testing and monitoring efforts. Providers are monitored annually for compliance with the Safety and Basic Assurance Review process to ensure that TB positive clientele are not denied treatment services and to ensure that effective referrals are made for health services in collaboration with local health departments. The Missouri Department of Health and Senior Services offers assistance to contracted providers to procure TB testing supplies and they continue to provide follow-up diagnostic services for clientele who do not have health care resources. The Department of Health and Senior Services has demonstrated their commitment to the provision of consistent TB services at the community level. Residential and opioid treatment programs are required to monitor client compliance with medications to encourage therapeutic response. The provider certification process assures that client medication compliance is addressed during the course of treatment.

FFY 2006 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to make Tuberculosis risk assessment, testing, and risk reduction education available to all treatment clientele. Provision of tuberculosis specific services will continue to be monitored with annual Safety and Basic Assurance Reviews. ADA will continue to require contracted treatment providers to maintain effective linkages with their community health departments to ensure that treatment clientele access and participate in tuberculosis services. Contracted providers may continue to expect ADA support to receive technical assistance and direct intervention at the community level if necessary TB services are not readily available. Regional collaborative technical assistance will continue to be offered to encourage a successful partnership between ADA contracted providers and Department of Health and Senior Services community health departments.

Missouri

Goal #6: HIV Services

GOAL # 6.-- An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY 2003 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued to work with the Department of Health and Senior Services (DHSS) to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed HIV/TB/STD/Hepatitis risk assessment for all clients. High-risk clientele were provided with pre-test counseling, testing referral, and post-test counseling services.

ADA certification standards required staff providing information about HIV/AIDS to complete a Department of Mental Health approved or comparable training program. HIV Risk Reduction Counseling training is provided annually in each region, free of charge, to service providers. ADA maintained a collaborative partnership with the DHSS to obtain current resource materials, and to receive technical assistance for effective intervention strategies.

ADA's Treatment Coordinator remained an active participant of Governor's Council on AIDS. Active participation with this council ensured ADA engagement with Missouri state initiatives to address the needs of the HIV/AIDS population, and provided the Council with information regarding ADA and the DHSS collaboration.

FFY 2005 (Progress)

The Division of Alcohol and Drug Abuse (ADA) has continued to monitor the incidence rates of HIV/AIDS for those programs that provide on-site testing. ADA does not currently reimburse for on-site testing. However, all contracted treatment providers continue to be required to arrange for client testing services at any time during the provision of treatment services.

To further decrease perinatal HIV transmission, ADA has required all Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children to coordinate the prenatal care of all female clients. This practice has continued to ensure all female clientele have access to prenatal care to encourage the client to address the issue of HIV testing with their physician and the medical facility. Monitoring of compliance is accomplished during Certification Surveys and annual Safety and Basic Assurance Reviews.

ADA supports the Department of Health and Senior Services' (DHSS) promotion of the OraQuick HIV testing protocol for timely diagnosis of positives and to encourage earlier identification of client counseling and referral needs. Training for the new OraQuick HIV testing protocol is currently being provided by the DHSS to ADA contracted providers, who wish to provide on-site testing for HIV, to ensure that they are compliant with the reporting requirements of this testing protocol.

ADA and the Department of Senior Services has continued to promote regional collaborative efforts between community health providers and substance abuse providers to reduce the incidence and spread of sexually transmitted and blood borne diseases. ADA collaborated with the DHSS to provide the first regional cross-training curriculum in the fall of 2004 to address substance abuse's role in the spread of sexually transmitted diseases and blood borne diseases. Subsequent regional action plans were developed to identify and prioritize regional cross-training goals for the fall of 2005. Continued collaboration between ADA and the DHSS has resulted in provision of Community Connections Resource Directory training, in cooperation with the University of Missouri-Columbia, to encourage regional development and maintenance of resource directories.

Additional regional collaborative cross-training is planned for the fall of 2005 to provide prevention intervention strategies to substance abuse providers assist them to strengthen their risk reduction effectiveness with their clientele. Prevention providers will be provided with more information about treatment services and effective referral practices. Regional providers will be encouraged to form regional provider networks to promote effective service provision linkages. Regional providers will offer the cross-training elements of this training agenda. ADA and DHSS staff will facilitate this knowledge exchange, and assist the regions with region specific technical assistance.

A memo of understanding between ADA and the DHSS has been finalized. This will serve to strengthen ADA's commitment to collaborate with the DHSS to provide

effective intervention strategies to our providers to help them to effectively address risk reduction practices with ADA's high-risk clientele, to reduce the spread of sexually transmitted and blood borne diseases.

FFY 2006 (Intended Use)

Continued efforts will be made to decrease perinatal HIV transmission. The Division of Alcohol and Drug Abuse (ADA) will continue to require all Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children to coordinate the prenatal care of all female clients. This practice will ensure that female clientele have access to prenatal care to encourage the client to address the issue of HIV testing with their physician and the treating medical facility.

ADA and the Department of Health and Senior Services (DHSS) will continue to collaborate to develop regional provider service networks to promote knowledge exchange between ADA and the DHSS providers to address the need for effective risk reduction strategies with ADA's high-risk clientele. ADA contracted substance abuse, and prevention providers will be encouraged to maintain effective working partnerships with community health and community prevention service providers to meet the needs of their at-risk clientele.

The DHSS will continue to make HIV testing education available to ADA contracted providers who wish to provide on-site HIV testing. ADA will make technical assistance available to all contracted providers who wish to provide on-site HIV testing services.

The DHSS has encouraged ADA to address the co-infection rate of HIV and Hepatitis C among the IV Drug use population. ADA will continue to require assessment for hepatitis risk with the initial assessment process. ADA staff members were encouraged to attend a June 2005 Hepatitis train-the-trainer workshop sponsored by the Hepatitis C Support Project. This training was provided to the DHSS to prepare health and treatment educators to train provider staff to implement updated information on transmission, prevention, symptoms, and treatment for Hepatitis. The educational materials provided during this training will be utilized to prepare a current provider curriculum, which will be distributed to ADA contracted providers. ADA contracted providers will be encouraged to provide hepatitis curriculum with their HIV education as a risk reduction strategy.

The DHSS will initiate a state wide Hepatitis Plan of Action to address prevention and care of Hepatitis in the fall of 2005. ADA will serve as an active participant in this collaborative process to address with the Hepatitis prevention, and treatment intervention needs of the substance abuse population.

ADA will encourage the Partners In Prevention, a university and college campus-based prevention program to establish regional collaborative partnerships with the Statewide Community Planning HIV Prevention Group to encourage their identification and use of effective intervention HIV risk reduction strategies with their college population.

Missouri

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2003) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

· development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
· the role of the single State authority (SSA) for substance abuse prevention and treatment; and
· the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

· the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
· the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
· the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
· technical assistance.

Since 1989 the Division of Alcohol and Drug Abuse (ADA) has provided TB and HIV services in the four publicly-funded methadone programs, and other selected treatment programs. Linkages between early intervention services for HIV and the IVDU Outreach Programs included methadone service providers as well as other identified efforts, particularly in St. Louis and Kansas City.

Since July 1, 1993 all substance abuse treatment programs have provided TB and HIV services to clients entering treatment by arranging with a nearby health clinic to provide clients with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. All clients, whether admitted or not, are offered the service. Follow up counseling and ongoing services are then provided collaboratively between the substance abuse provider and the health clinic. An ADA Treatment Specialist coordinates the HIV and TB services with the Department of Health and Senior Services (DHSS), local county health departments, and substance abuse programs to ensure services are available to all clients.

These services and local linkages between substance abuse programs and local clinics were evenly distributed statewide and involved all contracted program sites. All clients received a HIV/STD/TB/Hepatitis Risk Assessment at admission to treatment and appropriate referrals were made. Pre and post test counseling, testing and HIV education was available to clients in substance abuse treatment.

A Treatment Specialist from ADA maintained continued contact with contracted agencies and coordinated technical assistance education. A qualified contracted provider conducted regional trainings for treatment providers regarding HIV Prevention and Pre/Post Test Counseling. Additional services were provided to ADA by the Department of Mental Health, Office of Medical Affairs in the form of technical assistance and consultation. ADA adhered to the protocols established by the U. S. Centers for Disease Control and Prevention and the DHSS.

The responsibility for public health and communicable diseases is a secondary role, requiring close coordination of policy and program priorities between the DHSS and the Missouri Department of Mental Health.

ADA has a current Memorandum of Understanding (MOU) with the DHSS which identifies a working understanding related to prevention of communicable disease. This MOU identifies that ADA will collaborate with DHSS to strengthen community access to and utilization of HIV prevention and care services, STD, Hepatitis, and TB educational, screening, and treatment services. In FY 2005 a total of $925,524 in Missouri state funds were spent on TB services including $53,233 spent on clients who were substance abusers in treatment.

Missouri

Goal #7: Development of Group Homes

GOAL # 7.-- An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2003 (Compliance): (participation OPTIONAL)

FY 2005 (Progress): (participation OPTIONAL)

FY 2006 (Intended Use): (participation OPTIONAL)

Compliance FFY 2003

In 2003, the Department of Mental Health, Division of Alcohol and Drug Abuse opened five (5) men's Oxford Houses. A continued need for safe and affordable housing exists in Missouri and indications are this will be the case for many years to come. Housing specialists employed by the state, continue to monitor and provide technical assistance to 47 houses for men and14 houses for women.

Progress FFY 2005

The Department of Mental Health, Division of Alcohol and Drug Abuse continues to support the Oxford House program within the State of Missouri. Through careful selection of prospective house locations, the stabilization of Oxford House program has been maintained.

Intended Use FFY 2006

The housing needs of recovering alcoholics and substance abusers will continue to be a high priority in the future. The state of Missouri will continue to support the group home program to assure adequate housing for individuals completing treatment and seeking safe and affordable housing. The Department of Mental Health, Division of Alcohol and Drug Abuse will continue to assist in opening and providing technical assistance to the Oxford House program.

Missouri

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs

(See 42 U.S.C. 300x-25; 45 C.F.R. 96.129; and 45 C.F.R. 96,122(f)(1)(vii))

If the state has chosen in Fiscal Year 2003 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2003 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

• the number and amount of loans made available during the applicable fiscal years;

• the amount available in the fund throughout the fiscal year;

• the source of funds used to establish and maintain the revolving fund;

• the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;

• the private, nonprofit entity selected to manage the fund;

• any written agreement that may exist between the State and the managing entity;

• how the State monitors fund and loan operations; and

• any changes from previous years' operations.

Attachment F

The Anti-Drug Abuse Act of 1988 (Pub. I. 100-690, approved November 18, 1988) amended Subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x) by adding a new section 1916A establishing a program entitled Group Homes for Recovering Substance Abusers.

Under the Alcohol and Drug Abuse and Mental Services (ADMS) Block Grant, the Missouri Department of Mental Health (DMH) established the Group Home Revolving Loan fund by contract with the Missouri Housing Development Commission (MHDC) effective August 11, 1989. In 2002, the DMH contracted with Oxford House, Inc. to manage the Revolving Loan Fund. States were required to establish the revolving fund in the amount of $100,000. States must establish, directly or through the provision of a grant or contract to a non-profit entity, a revolving loan fund.

By law, individual loans for the establishment of programs to provide housing may not exceed $4,000 each. The loans are to be repaid within a 2 year period. These funds are to be used to provide start-up loans to groups of recovering individuals.

As stipulated in accordance with the specifications in the Block Grant legislation, the loans have specific requirements. An application must be submitted to the DMH and signed by at least six recovering individuals who have completed alcohol and/or drug treatment. They must want to start a self-run, self-supported alcohol and drug free house. After reviewing the application, the DMH forwards the application to Oxford House World Services where a review is completed; a check is then forwarded to the applicant (borrower). Loan checks are not made payable to individuals but in the name of the house which is designated by the name of the street or town where it is located. Loan repayment schedules are in 12, 18, or 24 month installments. No loan payments are due for the first 30 days after the original loan is issued. No interest is charged to the borrower on the principal on the loan. Repayments are made to Oxford House World Services where they are deposited into the revolving loan fund. Late payments from the borrower are assessed a 20% or $25.00 if not received as scheduled.

There were seven (7) loans made in 2003 totaling $29,000 of which five (5) were new Oxford House openings and two (2) were refinancing for existing houses. The amount of funds available at the time of these loans was between $11,903 and $34,000. Other existing loans were being repaid while new loans were approved to open the new houses. A monthly report is forwarded by Oxford House World Services giving details for each loan and payment schedule. Every house that has a loan receives a payment book and is contacted if scheduled payments are late or have not been received.

The Oxford House Drug Free Group Home Specialist receives the loan report from Oxford House World Services detailing the activity of every house on a monthly basis. Any house experiencing financial difficulty is contacted and counseled by the Drug Free Group Home Specialist who is employed by the DMH. Technical assistance is provided by the Drug Free Group Home Specialist and can be contacted through an 800

telephone number. There are two individuals who are employed by the DMH that comprise this team. Through publications, meetings and workshops the Division of Alcohol and Drug Abuse has made education of the Oxford House concept a priority for legislators, communities, and local government agencies throughout Missouri.

As of June 30, 2003, 101 loans have been committed in Missouri for drug-free group homes. These homes are located in 15 Missouri cities. More than $329,000 has been loaned to open Oxford Houses in Missouri since 1989. There are 61 houses in the state where 365 men and 73 women make their home.

Missouri was one of a few states that initially welcomed the Oxford House program when it was first offered. Since that time, Missouri has seen its share of successes and failures. Because it has been through the good and tough times, Missouri recognizes the value of continuing to provide safe and affordable housing programs for individuals after their completion of substance abuse treatment.

CENTRAL REGION			
Alhambra	107 E. Alhambra	Columbia, MO 65203	M 573/443-2640
Bicknell	104 Bicknell	Columbia, MO 65203	M 573/442-7084
Calico	2504 Calico St.	Columbia, MO 65202	M 573/474-0035
Cougar	600 Rogers St.	Columbia, MO 65203	M 573/442-2330
Jewell	111 Benton St.	Columbia, MO 65203	W 573/256-4831
Leslie	19 E. Leslie	Columbia, MO 65202	M 573/256-5221
Main Street	1601 S. Franklin St.	Kirksville, MO 63501	M 660/665-3297
Nelwood	2501 Nelwood Dr.	Columbia, MO 65202	M 573/814-0888
Proctor	314 Proctor Dr.	Columbia, MO 65202	M 573/874-9610
Quail	2614 Quail St.	Columbia, MO 65202	M 573/814-3900
Rothwell	220 Elliott Dr.	Columbia, MO 65201	W 573/256-8501
Seales	1400 W. Main St.	Jefferson City, MO 65109	M 573/635-7567
Sondra	921 Sondra	Columbia, MO 65203	M 573/875-5721
Spring Valley	338 Crown Point	Columbia, MO 65203	W 573/443-3571
Willowbrook	2501 Willowbrook Ct.	Columbia, MO 65203	M 573/474-0741
EASTERN REGION			
Allendale	3127 Meramec St.	St. Louis, MO 63118	M 314/353-5823
Chippewa	6408 Chippewa	St, Louis, MO 63109	M 314/353-2771
Clayton	6957 Clayton Rd.	St. Louis, MO 63110	M 314/863-7669
Fairview	2171 Hwy. 61	Festus, MO 63028	M 636/937-2514
Fountain	4848 Fountain	St. Louis, MO 63113	W/C 314/361-1829
Gravois	3943 Gravois	St. Louis, MO 63110	M 314/772-1303
Humphrey	3542 Humphrey	St. Louis, MO 63118	M 314/865-2928
Jarman	4506 S. Grand	St. Louis, MO 63118	W 314/351-1567
Kensington	5058 Kensington	St. Louis, MO 63108	M 314/367/7962
Lusher	11876 Lusher Rd.	Florissant, MO 63138	M 314/741-7536
McCausland	2017 McCausland	St. Louis, MO 63143	M 314/644-0971
McDonough	527 McDonough	St. Charles, MO 63303	M 636/947-6730
Michigan	7127 Michigan Ave.	St. Louis, MO 63118	M 314/351-2712
Monitor	3633 Meramec	St. Louis, MO 63116	W 314/752-1213
Montana	3655 Montana	St. Louis, MO 63116	M 314/351-2064
Oak Lake	11100 Oak Lake	Creve Coeur, MO 63146	W 314/432-5515
Osage	2715 Osage St.	St. Louis, MO 63118	W 314/772-6771
Portis	4430 Arsenal	St. Louis, MO 63118	M 314/776-5828
Shenandoah	720 Shenandoah	St. Louis, MO 63104	M 314/776-4883
St. Charles	225 N. 5th St.	St. Charles, MO 63301	M 636/940-0741
Winfield	60 Frankie Dr.	Winfield, MO 63389	M 636/566-6258

WESTERN REGION			
Blue Hills	1832 E. 49th St.	Kansas City, MO 64111	M 816/921-1012
Brookwood Avenue	5123 Brookwood Ave.	Kansas City, MO 64110	W 816/861-2176
Felix	1419 Felix	St. Joseph, MO 64501	M 816/232-4773
Harrison	26 East Concord	Kansas City, MO 64109	M 816/237-1925
Hillcrest	9719 Hillcrest Rd.	Kansas City, MO 64134	M 816/761-3948
Holmes	2741 Holmes	Kansas City, MO 64108	M 816/842-1634
Karnes	3734 Walnut Ave.	Kansas City, MO 64109	W 816/931-6731
Marlboro	1410 E. 77th Terrace	Kansas City, MO 64131	M 816/333-2267
Museum Hill	1210 Felix	St. Joseph, MO 64501	W 816/676-2323
Northeast	1229 Benton Blvd.	Kansas City, MO 64129	M 816/231-8086
Norwood	2934 S. Norwood	Independence, MO 64050	M 816/252-5703
Olive	3221 Olive St.	Kansas City, MO 64101	W 816/923-7063
Rockhill	5632 Charlotte	Kansas City, MO 64110	M 816/822-7134
St. Joseph	507 S. 10th	St. Joseph, MO 64501	M 816/232-8988
SOUTHWESTERN REGION			
Catalina	1674 S. Catalina	Springfield, MO 65807	M 417/887-7783
Hynes	307 Hynes St.	West Plains, MO 65775	M 417/253-0157
Ingram Mills	3215 E. Southern Hills	Springfield, MO 65807	M 417/877-8562
Kansas Avenue	1558 W. Cherokee	Springfield, MO 65807	M 417/832-0796
Kerr	953 W. Kerr	Springfield, MO 65803	M 417/864-6316
National	820 S. McCann St.	Springfield, MO 65802	W 417/863-0244
Moffet	529 Moffet St.	Joplin, MO 65801	M 417/623-4347
Mount Branson	1154 Easy HWY 76	Branson, MO 65616	M 417/334-4696
6th Street	603 E. 6th St.	Branson, MO 65616	M 417/339-2826
Vaughn	1002 Chippewa	Branson, MO 65616	M 417/339-2826
Wall	1422 S. Wall Ave.	Joplin, MO 64804	W 417/623-8984
TECHNICAL ASSISTANCE STAFF			
1/800-575-7480 ADA Toll Free Number			
Jacquie Lockett	314/877-0386		
David Cikesh	816/482-5763		
M = Men	W = Women	W/C = Women & Children	
Revised 6/22/05			

Missouri

Goal #8: Tobacco Products

GOAL # 8.--An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

. Is the State's Synar report included with the FY 2006 uniform application?
Yes No

. If No, please indicate when the State plans to submit the report:

mm/dd/2005

Yes, the State of Missouri included its submission of the annual Synar Report with the FY2006 uniform application.

Missouri

Goal #9: Pregnant Women Preferences

GOAL # 9.-- An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FY 2003 Compliance

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) has developed specialized Comprehension Substance Treatment and Rehabilitation (CSTAR) programs for women and children. ADA certification standards and provider contracts require that pregnant and postpartum women be given admission priority. Monitoring procedures are in place to assist pregnant women in accessing treatment as quickly as possible. Agency activity levels are monitored at the regional level through the Regional Administrators and Area Treatment Coordinators. The CTRAC information system designed and maintained by the DMH has a registration option of screening/waiting rather than admission. ADA encourages each provider to maintain contact with those clients on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have developed informal telephone communications to refer clients to other programs when they are unable to meet the needs of those clients seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating treatment services throughout the state. ADA has a toll-free number advertised for consumers to call for referrals. Central office or regional staff receive the calls and make referrals to treatment programs in the consumer's area. Compliance was monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by regional staff.

FY 2005 Progress

Pregnant women continue to receive admission priority as required by provider contacts and certification standards. Compliance continues to be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by regional staff. The results of this monitoring activity demonstrate that pregnant women are being admitted to treatment and receiving services as required.

FY 2006 Intended Use

Pregnant women will continue to receive admission priority as required by provider contract and certification standards. Missouri received the Access to Recovery Grant this year which should provide additional treatment resources and assure that pregnant women will continue to be admitted immediately upon presenting themselves for treatment. Compliance will continue to be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by regional staff.

Missouri

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2004) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;

- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;

- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and

- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;

- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and

- technical assistance.

Attachment G

The Single State Agency for the State of Missouri addresses the requirements for developing capacity management and waiting list systems for intravenous drug users and pregnant women through several methods:

1. Certification Standards for Alcohol and Drug Abuse Programs

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in standards imposed on providers of treatment services through the Certification Standards for ADA programs. These Certification Standards are codified as state regulations in the Code of State Regulations (CSR) and filed with the Missouri Secretary of State. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and to plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact), any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.
2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.
3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;
2. Shall be responsive to the individual's request and needs; and
3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

9 CSR 30-3.190 (1) (Specialized Program for Women and Children) requires that in programs that provide treatment solely to women and children, priority is given to women who are pregnant or postpartum.

9 CSR 10-7.010 (6) (Treatment Principles and Outcomes) requires (A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria and (7) Essential Treatment Principle—Array of Services.

(A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.
2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.
3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.
4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.
5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

9 CSR 3.100 (14) (Services Delivery Process and Documentation) requires that the Division of Alcohol and Drug Abuse conduct clinical review to "promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definition."

9 CSR 30-3.132 (5) (Opioid Treatment Program) requires "the program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive."

Agencies within close proximity of each other have developed informal telephone communications to refer clients to other programs when they are unable to meet the needs of those clients seeking treatment. This has proven to be an effective process. Also, the Division of Alcohol and Drug Abuse assists agencies in locating referral resources throughout the state.

Funds Expended or Obligated for the Federal Fiscal Year two years prior to the year for which the State is applying for funds:

These certification standards are part of the ongoing operations of the Missouri Division of Alcohol and Drug Abuse (ADA). In addition, the statewide network of treatment providers provides an easy vehicle for communication across provider agencies on topics related to treatment capacity. No direct costs can be attributed to complying with the capacity management and waiting list requirements of the block grant.

2. Information systems: Client Tracking, Registration, Admission, and Commitment (CTRAC)

The CTRAC information system designed and maintained by the Missouri Department of Mental Health (DMH) has a registration option of screening/waiting rather than admission. ADA allows each provider to maintain contact with those clients on their waiting list in the manner each provider determines best or appropriate for their particular agency.

Funds Expended or Obligated for the Federal Fiscal Year two years prior to the year for which the State is applying for funds:

CTRAC is a component of the DMH's client information infrastructure. Costs for complying with block grant capacity management and waiting list requirements are part of the ongoing costs of this infrastructure and cannot be estimated.

3. Toll-free Telephone Number

ADA has a toll-free number advertised for consumers to call in for referrals. Either central office or regional staff receive the calls and make referrals to treatment programs in the consumer's area.

A long standing policy of ADA has been pregnant women and intravenous drug users are priority populations for treatment admission and must not be placed on a waiting list for treatment. When a member of these priority populations presents for service they are promptly screened, assessed and immediately engaged in the level and intensity of care that is clinically appropriate to meet the consumer's needs. While the level and intensity of treatment to meet the consumer's needs is always available, residential support, a bed, is not always available. In this situation the ADA policy has been that the agency shall transition a consumer who is not a member of a priority population from residential support to transitional or supportive housing or other appropriate housing plan to make room in the residence for the consumer who is a member of the priority population.

While the above procedure has worked reasonably well in light of limited resources, during the next fiscal year ADA plans to amend the contracts of treatment providers to specifically address the above procedure and a mechanism to track the utilization.

ADA does not identify costs separately for capacity management and waiting list systems; these costs are included in our administrative costs.

Missouri

Goal #10: Process for Referring

GOAL # 10.-- An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY 2003 Compliance:

Data from the St. Louis Targeted Cities program permitted Missouri's Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) a unique opportunity to evaluate the quality of client agency matching, client progress in treatment, and treatment outcomes. The standard computerized client assessment tool developed during this grant, Initial Standardized Assessment Protocol (ISAP), has enhanced the ability of providers and ADA to perform three important functions. The ability to identify the most appropriate intensity level of care for each client is enhanced. Data collection enabling utilization review and outcome measures is now possible. Comprehensive identification of problem areas for treatment planning is also enhanced. All treatment providers statewide have been trained to use the ISAP. The ISAP contains separate assessments for adult and adolescent clients.

The Addiction Severity Index (ASI) is the primary assessment tool used to determine level of care for clients age eighteen years and older. The ASI is a structured clinical interview which is typically conducted in less than fifty minutes at the time of the client's admission. This assessment tool encompasses seven areas of life function: medical status; employment status; drug and alcohol use; family history; family and social relationships; legal status; and psychiatric status.

The Missouri Adolescent Comprehensive Substance Assessment (MACSA) was designed by a workgroup of Missouri adolescent treatment providers. The MACSA is a structured clinical interview which is typically conducted at the time of the adolescent's admission to treatment. This assessment tool encompasses seven areas of life function: legal, school and work; behavior and emotions; friends; family; recovery environment and placement.

All providers are using the ISAP and either batching information or using the internet virtual private network to input the data directly to a data warehouse for information retrieval by ADA. ADA staff review utilization data on an agency-by-agency basis to identify major trends, problem areas, and successful outcomes. Providers are utilizing the computerized ISAP to assure clients are provided the most appropriate level of care. The tool permits greater ability to perform utilization review and outcome measurement.

Certification standards require individuals meet eligibility criteria for admission into each level of the continuum of care.

9 CSR 30-3.120 Detoxification
(3) Eligibility Criteria: In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:
(A) Demonstrates a current inability to minimally care for one self;

(B) Lacks a supportive, safe place to reside and demonstrates a likelihood of continued use of alcohol or other drugs;
(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or
(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

9 CSR 30-3.140 Residential Treatment
(2) Eligibility Criteria: In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:
(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;
(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;
(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following:
1. Recent patterns of extensive or severe substance abuse;
2. Inability to establish a period of sobriety without continuous supervision and structure;
3. Presence of significant resistance or denial of an identified substance abuse problem; or
4. Limited recovery skills and/or support system; and
(D) A client may qualify for transfer from outpatient to residential treatment if the person:
1. Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or
2. Presents imminent risk of serious consequences associated with substance abuse.

9 CSR 30-3.130 Outpatient Treatment
(4) Community-Based Primary Treatment: This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.
(A) Eligibility for primary treatment shall be based on:
1. Evidence that the person cannot achieve abstinence without close monitoring and structured support; and
2. Need for frequent, almost daily services and supervision.

(5) Intensive Outpatient Rehabilitation: This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on:

1. Ability to limit substance use and remain abstinent without close monitoring and structured support;
2. Absence of crisis that cannot be resolved by community support services;
3. Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and
4. Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(6) Supported Recovery: This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on:

1. Lack of need for structured or intensive treatment;
2. Presence of adequate resources to support oneself in the community;
3. Absence of crisis that cannot be resolved by community support services;
4. Willingness to participate in the program, keep appointments, participate in self-help, etc.
5. Evidence of a desire to maintain a drug-free lifestyle;
6. Involvement in the community, such as family, church, employer, etc.; and
7. Presence of recovery supports in the family and/or community.

9 CSR 30-3.132 Opioid Treatment Program

(5) Admission Criteria: The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1. The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program

physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2. For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of the Division of Alcohol and Drug Abuse; and

3. An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1. The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2. At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D) The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

ADA's Clinical Utilization Review Unit makes determinations regarding the appropriate level of care for consumers according to certification standards.

(14) Clinical Utilization Review: Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B) Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C) Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1. Length of stay beyond any specified maximum time period;
2. Service authorization beyond any specified maximum amount or cost;
3. Admission of adolescents into adult programs; and
4. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA.

(D) Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E) The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.

(F) Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA regarding the utilization of particular services and total service costs; and

2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.

(15) Credentialed Staff: Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

FFY 2005 Progress:

The Internet web based version of the ISAP with data transported over a Virtual Private Network for confidentiality has become the only Department of Mental Health (DMH) supported version of the assessment. Most contracted agencies are using the Internet version of the ISAP called the "Outcomes Web". Agencies not yet on the Outcomes Web are receiving technical assistance.

Eligibility criteria contained within certification standards have been maintained. The Clinical utilization review unit continued to review service plans for compliance with certification standards, appropriateness of placements in the continuum of care consistent with ISAP assessment and acceptable standards of care.

Missouri was among 14 states and one tribal organization to be awarded an Access to Recovery (ATR) grant from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration. The Office of the Governor was awarded $7.6 million for each of three grant years for a total of $22.8 million. The Governor has designated the Division of Alcohol and Drug Abuse (ADA) to administer grant funds. The ATR program was fully implemented April 1, 2005. On this date, additional primary treatment programs were converted to Community Based Primary Treatment programs offering a continuum of treatment services based on the client's assessed needs.

ATR grants are intended to assist recipients in designing and implementing a voucher program to pay for an expanded array of community-based clinical substance abuse treatment and recovery supports. Keys to successful implementation of the ATR grant are to ensure genuine, free, and independent client choice of appropriate clinical substance abuse treatment and recovery supports.

The ATR funds will help to enhance all existing primary recovery programs to provide the full array of services including multiple levels of care and trauma services. In some cases, ADA will issue Requests for Proposals to expand services into areas that are underserved and in others they will credential nontraditional and faith-based organizations to provide recovery support services in their communities.

FFY 2006 Intended Use

The goal is to use the web based version of the ISAP statewide. The Division of Alcohol and Drug Abuse (ADA) will continue to review utilization data to identify patterns of success by agency. ADA is working on fine-tuning the ability to retrieve data in a meaningful fashion. ADA will continue to implement the outcomes measurement plan and assure reliable outcomes data is being collected to meet the federal requirements.

The clinical utilization review unit will continue to review service plans for compliance with certification standards, appropriateness of placements in the continuum of care consistent with ISAP assessment and acceptable standards of care.

An evaluation protocol is being implemented to track clients while they are engaged in treatment and after discharge to ensure that programs are demonstrating their treatment is effective and leads to recovery. Treatment effectiveness will be measured by seven outcome domains, including: 1) retention in treatment; 2) abstinence from alcohol and drug use; 3) no involvement with the criminal justice system; 4) attainment of employment or enrollment in school; 5) stable family and living conditions; 6) access and capacity to treatment; and, 7) involvement in the social supports of recovery.

All data collected to meet reporting requirements and conduct longitudinal outcome evaluation will be incorporated into the Customer Information Management, Outcomes, and Reporting (CIMOR) system. All service providers will be required to collect and enter this information into the CIMOR system. The Missouri Institute of Mental Health will serve as the contractor to collect data for the ATR project.

Missouri

Goal #11: Continuing Education

GOAL # 11.-- An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY 2003 (Compliance)

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 28-30, 2003 with over 850 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma and domestic violence, fetal alcohol syndrome, treatment planning for successful community outcomes, effective models for prevention in the treatment setting, and others.

The Division of Alcohol and Drug Abuse (ADA) treatment staff developed a series of training modules that were delivered to treatment and prevention providers throughout the state. These sessions were tailored to meet the needs of the staff in each agency. Over 80 on-site workshops were delivered during this fiscal year including Motivational Interviewing, Documentation, Treatment Planning, Confidentiality and Alcohol and Drug Federal Regulations, Addiction Ethics, and Outcomes Web Assessment.

ADA provided training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders. The training focus included community assessments, capacity building, and measurable outcomes.

ADA provided training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance was provided to promote community development, accountability, and targeted prevention initiatives based on CSAP's best practices program recommendations. ADA consistently collaborated with CSAP's Southwest Center for the Application of Prevention Technology (SWCAPT) to provide training and technical assistance for targeted prevention initiative.

ADA contracted with Development Systems, Inc. to provide five regional HIV pre and post test counseling trainings to substance abuse provider staff. The Missouri Department of Health and Senior Services has reviewed this curriculum and found it to meet the federal guidelines of the Centers for Disease Control and Prevention.

FFY 2005 (Progress)

The Department of Mental Health's annual Spring Training Institute was held May 18-20, 2005 and was attended by over 750 professionals from substance abuse prevention, treatment, and the mental health field. The theme of the conference was *Building for Tomorrow*. National and local experts shared information about a wide range of evidence based practices including risk reduction strategies for adolescents, special issues such as Bosnian and Hispanic populations, trauma symptom management, relapse prevention, including faith based practices and communities in treatment, and others.

The Division of Alcohol and Drug Abuse (ADA) treatment staff developed a series of training modules that were delivered to treatment and prevention providers throughout the state. These sessions were tailored to meet the needs of the staff in each agency. Staff from ADA's Treatment Section conducted over 70 on-site training sessions during the fiscal year including Treatment Planning, Documentation, Confidentiality and Ethics, Access to Recovery Addictions Academy, and Motivational Interviewing.

Regional Collaborative Model training was initiated in partnership with the Department of Health and Senior Services (DHSS) to reduce incidence of blood borne and sexually transmitted diseases among ADA clientele. Initial collaborative model trainings were conducted in all regions in Missouri. This training spawned regional action plans to address barriers to provider collaboration. All regions have now received Community Connection training to assist them in developing provider resources directories and regional partnership networks. Subsequent provider cross-training is planned for this fall to strengthen collaborative partnerships between ADA providers and DHSS providers and enhance their capacity to provide integrated services.

ADA continued to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance concerning community development, accountability, and target prevention initiatives were based on CSAP's best practices program recommendations. ADA collaborated with CSAP's Southwest Center for the Application of Prevention Technology (SWCAPT) to provide training and technical assistance for targeted prevention initiatives. Missouri Substance Abuse Prevention Specialists' training was held in April, 2005.

The annual statewide prevention conference, "Ignite our Spirits, Illuminate our Communities," was held August 5-8, 2004 in St. Louis. Missouri provided training and technical assistance on Prevention Community Readiness to five sites in Missouri as part of the SPF-SIG project planning.

In August, 2004, Missouri was co-sponsor of the 17th Annual National Prevention Network's Prevention Research Conference held in Kansas City, Missouri. The theme of the conference was "Cultivating the Past, Pioneering the Future." There were presentations on Prevention Theory and Advanced Prevention Science, Practical

Prevention Applications and/or Replications, Environmental Strategies, Research to Practice, and Emerging Prevention Issues.

ADA has continued its close collaboration with SWCAPT to provide training and technical assistance for targeted prevention initiatives. The SWCAPT is currently providing technical assistance to the Workforce Development Committee, known as the Missouri Prevention Network, to identify core competency requirements for levels of certification for prevention professionals. The SWCAPT also provides technical assistance to support the implementation of the Strategic Prevention Framework State Incentive Grant.

ADA contracted with Development Systems, Inc. to provide five regional HIV pre and post test counseling trainings to substance abuse provider staff. The DHSS approved the training curriculum as meeting the federal guidelines of the Centers for Disease Control and Prevention.

FFY 2006 (Intended Use)

The Department of Mental Health's Spring Training Institute will be held in May 2006. Continued collaboration with Mid-America Addiction Technology Transfer Center, CSAT, and CSAP will ensure that employees of treatment and prevention agencies in Missouri receive training and education on evidence-based practices.

The Division of Alcohol and Drug Abuse (ADA) will continue to contract with Development Systems, Inc. to provide additional regional HIV pre and post test counseling training to substance abuse provider staff. The training curriculum was approved by the Missouri Department of Health and Senior Services (DHSS) as meeting the federal guidelines of the Centers for Disease Control and Prevention.

ADA will continue to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance concerning community development, accountability, and target prevention initiatives will be conducted based on CSAP's best practices program recommendations. ADA will provide training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders.

The annual statewide prevention conference will be held August 4-7, 2005, in St. Louis, Missouri. The theme again will be, "Ignite Our Spirit, Illuminate Our Communities."

The Southwest Center for the Application of Prevention Technology (SWCAPT) will continue to provide technical assistance to ADA to support the implementation of the Strategic Prevention Framework State Incentive Grant. The statewide training and resource contract with ACT Missouri will build its FY 2006 training plan on the outcomes of the two workforce development surveys and the recommendations in the workforce development report. One of the report's recommendations is to match training opportunities with core competencies.

The Collaborative Model Initiative, in partnership with the DHSS, will be continued with provision of region specific technical assistance, to reduce the incidence of sexually transmitted and blood borne diseases. Regional action plans will be utilized to identify the specific training and technical assistance needs of each region. Continued training will be provided in partnership with DHSS to promote provider collaboration and strengthen service delivery.

Missouri

Goal #12: Coordinate Services

GOAL # 12.-- An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FY 2003 Compliance:

Certification standard 9 CSR 10-7.010 Treatment Principles and Outcomes states "(7) (A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.
2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.
3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.
4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.
5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals."

Adolescent CSTAR program certification standard 9 CSR 30-3.192 (3) (F) requires: "Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that the needs of youth in treatment are met and that services are coordinated. Coordination of service needs is critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas." Coordination of education for adolescent clients during treatment is required by standards.

All clients in CSTAR programs are offered a Community Support Worker whose responsibilities include "activities with or on behalf of a particular client in accordance with an individual rehabilitation plan to maximize the client's adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting client independence and responsibility." The community support worker arranges, refers, and monitors services external to the CSTAR program.

Each CSTAR Women and Children's program is required to provide a child care and development program for the children of women who are concurrently receiving treatment. Each center, as required in certification standards, must design appropriate services that address the following goals: building self esteem; learn to identify and express feelings; build positive family relationships; develop decision making skills; understand chemical dependency as a family illness; and learn and practice non-violent ways to resolve conflict. Each child receives an individual assessment to determine his/her needs and appropriate intervention or referral is arranged. Children can receive

individual and family therapy and group codependency counseling from qualified personnel. The mothers receive extensive weekly training on parenting skills and supervised parent/child bonding time to practice the new skills.

The women and their children receive residential support or supportive housing to assure a safe drug free environment. All women and children who enter treatment are provided health screenings by registered nurses to identify health deficits or needs for medical intervention. Close association with local health clinics provides prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. For women receiving day treatment and outpatient services transportation is available to and from the facility.

Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction.

In an outreach effort to impact the health risk practices of intravenous drug users, provider staff participated in collaborative model cross-training with the Department of Health and Senior Services (DHSS) to provide them with screening and risk assessment training to encourage their utilization of effective targeted risk reduction intervention strategies to address the high risk behaviors of intravenous drug abusers.

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the DHSS to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate Tuberculosis screening and treatment for all clients entering treatment programs.

ADA continued to work with the DHSS to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed HIV/TB/STD/Hepatitis risk assessment for all clients. High risk clientele were provided with pre-test counseling, testing referral, and post-test counseling services.

ADA's Treatment Coordinator remained an active participant of Governor's Council on AIDS. Active participation with this council ensured ADA engagement with Missouri state initiatives to address the needs of the HIV/AIDS population, and provided the Council with information regarding ADA and DHSS' agenda of collaboration.

In FFY 2003, DHSS was awarded a Fetal Alcohol Prevention grant from the Centers for Disease Control and Prevention (CDC), in which the ADA's Prevention Office was one of the partnering agencies. ADA is responsible for developing public education strategies and materials and implementing intervention activities for women of childbearing age. The Prevention Office initiated planning, which will result in staffs of Women and Children CSTAR programs being trained in a CDC-approved intervention.

ADA continued development of Missouri School-based Prevention and Intervention Initiative (SPIRIT). The Missouri SPIRIT program provided evidence-based prevention programs to students in grades K-12. This initiative provided universal, selective, and indicated preventive interventions. The curriculum used was Positive Action, Life Skills Training, Peace Builders, and Reconnecting Youth. One site is located in each of the five ADA sub-state regions.

FY 2005 Progress

CSTAR program certification standards continue to require the Division of Alcohol and Drug Abuse (ADA) and contracted treatment and prevention providers to maintain effective working relationships with other community resources to meet the emotional, mental, physical and spiritual needs of customers. ADA has provided numerous technical assistance visits and statewide meetings of providers to facilitate creative collaborative relationship with community resources.

ADA and contracted providers continue to be involved in collaborative disease prevention activities with the Department of Health and Senior Services (DHSS) including screening, risk reduction assessment and education and treatment of activity disease.

Two CSTAR programs continue the joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction.

Missouri was awarded an Access to Recovery Grant that will provide $7.6 million per year for the next three years to implement a statewide treatment voucher system. This will improve coordination and available alternatives among an increased number of qualified service providers; provide recovery support services through traditional, non-traditional and faith-based organizations and expand the existing managed care system.

Faith organizations and other nontraditional providers interested in providing recovery support services under the Access to Recovery project are required to become certified by completing the ADA's Addictions Academy. This training will provide for better coordination of the provision of treatment and recovery support services.

ADA is coordinating with the DOC on a Transition from Prison to Community Initiative. The goal is to assure substance abuse treatment and recovery support services are arranged in the community before an individual's release from a correctional institution.

ADA is also currently reviewing the system of care for individuals with co-occurring psychiatric and substance use disorders as part of the Co-Occurring State Incentive Grant. Eleven agencies are collaborating on this project.

During FFY 2005, ADA continued implementation of the Missouri School-based Prevention and Intervention Initiative (SPIRIT).The Missouri SPIRIT program provided evidence-based prevention programs to 4,687 students in grades K–12. The curricula used are *Positive Action*, *Life Skills Training*, *Peace Builders*, *2Good 4 Drugs, Second Step,* and *Reconnecting Youth*. Prevention providers also assist school personnel with identification and screening of students exhibiting problem behaviors. Missouri SPIRIT proposes to delay onset or decrease substance use, improve overall school performance, and reduce incidents of violence. The Missouri Institute of Mental Health

continued evaluation, collecting three types of data: individual, school or group, and program fidelity. In order to participate in the evaluation, both parental consent and student assent are required. A total of 1,857 students participated in the evaluation during FFY 2005. The following measures are being used: Teacher Observation Checklist, California Healthy Kids Survey, the Missouri Student Survey and Supplemental Survey, SPIRIT Fidelity and Quality of Program Implementation Report, Youth Satisfaction Survey, and the teacher-completed SPIRIT Initiative Questionnaire. Additional data collected on individual students includes grades, achievement test results, school attendance, suspensions, and incidence of violence, race, age, and gender. School level data are those that serve as indicators for each grade as a whole whether or not students were involved in the evaluation.

Missouri was awarded a Strategic Prevention Framework State Incentive Grant (SPF SIG) from SAMHSA. The SPF SIG has produced a prevention needs assessment report and a report on the prevention and early intervention programming and funding of state agencies. A Statewide Epidemiologic Workgroup has been established and is collecting information on problems and consequences of alcohol and other drug use and other related behavioral health disorders.

ADA provided initial regional collaborative model training for contracted prevention and substance abuse providers to link them with regional community health prevention staff. Regional action plans to identify strategies to enhance regional linkages between ADA contracted providers and DHSS contracted providers were generated from this initial technical assistance. Subsequent cross-trainings are planned for fall 2005 to enhance coordination and client access of community services.

Additionally, ADA is a partner with the DHSS for a five-year award from the Centers for Disease Control and Prevention (CDC) focusing on Fetal Alcohol Syndrome Disorder. All CDC awards are adapting Motivational Interviewing Technique and the Personal Choices program for implementation. A state specific Motivational Interviewing Technique and Personal Choices program model is currently under development for implementation in three CSTAR sites. The CDC award also includes Fetal Alcohol Syndrome Disorder training for the three CSTAR sites.

FY 2006 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to require coordination of substance abuse treatment with community resources to provide additional recovery support services to meet the needs of consumers. Housing, transportation, vocational rehabilitation, education and family services will continue to be addressed in CSTAR programs. Specialized programs for adolescents, the opiate addicted or pregnant and/or women with dependent children will continue to provide substance abuse treatment. These specialized programs not only provide additional programming but also maintain collaborative relationships with external community agencies to provide recovery support services to meet the special needs of the population serviced.

ADA and contracted providers continue to be involved in collaborative disease prevention activities with the Department of Health and Senior Services (DHSS) including screening, risk reduction assessment and education and treatment of activity disease.

ADA will continue to work with the Department of Corrections to improve the transition of offenders from prison to community.

The co-occurring state incentive grant project will continue to identify and implement needed system changes to meet the needs of clients with co-occurring disorders. This will improve the integration of substance abuse treatment with existing mental health services.

ADA is a partner with the DHSS for a five-year award from the Centers for Disease Control and Prevention (CDC) focusing on Fetal Alcohol Syndrome Disorder. All CDC awards will be implementing Motivational Interviewing Technique and the Personal Choices program. Three CSTAR sites will be implementing the Personal Choices program and receiving Fetal Alcohol Syndrome Disorder training.

As a result of budget cuts, ADA will reduce funding for the Missouri School-based Prevention and Intervention Initiative (SPIRIT). ADA will continue to provide funding for program implementation and evaluation at three of the five SPIRIT sites. The evaluators will continue to track the number of referrals made through the project.

The Missouri Student Survey will be available to all of the state's 524 local school districts as a result of collaboration with the Department of Elementary and Secondary Education, which allows for Internet-based administration of the survey. Local school districts and ADA will continue to use survey results for planning and program development.

Missouri

Goal #13: Assessment of Need

GOAL # 13.-- An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY 2003 (Compliance)

The Missouri Division of Alcohol and Drug Abuse (ADA) completed its work on Missouri's second State Treatment Needs Assessment Program (STNAP-II) grant funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, under CSAT Grant No. 5H79 TI12229. Research Triangle Institute (RTI), ADA's subcontractor, submitted review drafts of the project's three study reports to ADA. Revisions and technical corrections to the study reports were completed by ADA and RTI in FFY 2003, and copies of the study reports and project final reports were submitted to SAMHSA for project close-out.

ADA completed the Prevention Needs Assessment studies in December 2002. The studies' reports *Substance Abuse Prevention Needs in Missouri Counties, Missouri Community Resource Assessment,* and *Integrating Findings from Missouri's Substance Abuse Prevention Needs* were posted and continue to be available through Missouri's prevention website – www.MissouriPrevention.org. ADA, in collaboration with the Missouri Department of Elementary and Secondary Education (DESE), integrated the student survey instruments used by DESE and ADA into a single instrument in preparation for the 2004 Missouri Student Survey. Also, ADA and DESE agreed to administer the 2004 survey over the internet using the SmartTrack application.

FFY 2005 (Progress)

The three reports from the STNAP-II study -- *Substance Abuse and Need for Treatment Among Missouri Jail Inmates, 2001; Substance Use and Need for Treatment Among the Household Population in Missouri, 2001/2002; and Integrating Population Estimates of Treatment Need in Missouri: 2003 Update* – continued to be posted on the website of the Missouri Division of Alcohol and Drug Abuse (ADA). Prevalence data from the studies was discussed in the narrative section of the *Status Report on Missouri's Alcohol and Drug Abuse Problems—Eleventh Edition*, April 2005, and summary tables of the integrated estimates were developed and included in the data section of the report. The Status Report was also posted to ADA's website. Data from the STNAP-II study were used in allocation decisions for the Access to Recovery grant implementation and in performance measurement data for ADA's portion of the Missouri Department of Mental Health FY 2006 budget request.

ADA administered the 2004 Missouri Student Survey in the spring and fall of 2004. (Two of the state's largest school districts, Kansas City and St. Louis City, were not able to take the survey in the spring; therefore, access to the survey was extended into the fall). The Missouri Department of Elementary and Secondary Education (DESE) and ADA set a precedent in developing a single survey instrument used by both agencies. The collaborative effort produced an instrument to collect data on incidence and prevalence; risk and protective factors; and to address both agencies' planning needs by providing data at the school district, county, and state levels. ADA developed school-age youth substance abuse and delinquent behavior trend data and risk and protective factor profiles. ADA continued to develop a systematic, data driven approach to estimate prevention needs statewide and regionally. The prevention planning process broadened in scope through the addition of the "Missouri Governor's State Prevention Initiative". Missouri was awarded a State Incentive Cooperative Agreement (CSAP Grant # 1 U79 SP11194-01) effective September 30, 2004 (Strategic Prevention Framework State Incentive Grant, SPF SIG). The Missouri Governor's Prevention Initiative is a partnership among state agencies, community stakeholders, interest groups and individuals to improve the outcomes for Missouri's youth, families and communities. Three reports are in press: *Prevention Needs Assessment, Missouri Prevention Workforce Survey,* and *PREVENTION ACTIVITIES OVERVIEW: Missouri's State-Level Prevention Planning Activities.* In addition, a Statewide Epidemiological Workgroup, comprised of epidemiologists and researchers from local, state, and federal agencies and universities, has been established and is preparing a report on substance use, problems, and consequences. A draft of the report is scheduled for review in August 2005.

In December 2004, ADA published the second year report of its school-based prevention and intervention initiative, SPIRIT. The evaluation component of SPIRIT uses three different instruments to measure how well children and youth are progressing as a result of the program. Children in grades K-3 are assessed by teachers using a form that measures changes in aggression and social skills; students in grades 4–5 complete an approved, localized version of the California Healthy Kids

Survey, which assesses risk and protective factors related to adolescent substance use; and students in grades 6–12 complete the SPIRIT Survey, which is an adaptation of the Missouri Student Survey and measures substance use, family management, stress management, decision making, self-esteem, perceived risk of using substances, frequency of anti-social behavior, and attitudes toward substance use. Additional data is collected on students in grades 4–12, including grades, disciplinary incidents, school attendance, race, age, and gender.

FFY 2006 (Intended Use)

Prevalence data from the STNAP-II study will continue to be used in sub-state treatment planning involving specific target populations. The data will also be used to calculate and track the public sector treatment penetration rates in the Performance Measurement report updated periodically by the Missouri Division of Alcohol and Drug Abuse (ADA). Summary information from the prevalence study will be provided in the twelfth edition of the *Status Report on Missouri's Alcohol and Drug Abuse Problems* scheduled for completion in April 2006. The Governor's Substance Abuse Prevention Initiative Advisory Committee is developing criteria for allocating funds for program implementation under the Strategic Prevention Framework State Incentive Grant (SPF SIG), and has identified Overall Prevalence of substance abuse as one of the criteria to be examined. The Advisory Committee, in conjunction with the State Epidemiology Workgroup, will utilize Geographic Information System maps depicting ADA's Service Area prevalence estimates and rates for special populations quantified in the STNAP-II study.

ADA will continue the biennial Missouri Student Survey. The survey, which is available online, will be available to all 524 of Missouri's school districts. ADA is anticipating that 100,000 students in grades 6–12 will participate. ADA will continue to collect data on the progress of students participating in the school-based prevention and intervention initiative. Additional state and local surveys will be developed and administered through the SPF SIG.

Missouri

Goal #14: Hypodermic Needle Program

GOAL # 14.-- An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY 2003 Compliance

The Division of Alcohol and Drug Abuse (ADA) has continued the policy ensuring no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. ADA's contracts with treatment providers state: "The contractor agrees and understands that payments received under the contract SHALL NOT be expended in the following manner: to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection."

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways; three year Certification Survey's, Annual Safety and Basic Assurance Reviews and periodic site visits by the Regional Administrators and Area Treatment Coordinators.

FFY 2005 Progress

The Division of Alcohol and Drug Abuse (ADA) has continued the policy ensuring that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways; three year Certification Survey's, Annual Safety and Basic Assurance Reviews and periodic site visits by the Regional Administrators and Area Treatment Coordinators.

FFY 2006 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue the policy ensuring that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Contract providers will continue to be required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy will be ensured through; three year Certification Survey's, Annual Safety and Basic Assurance Reviews and periodic site visits by the Regional Administrators and Area Treatment Coordinators.

Missouri

Goal #15: Independent Peer Review

GOAL # 15.-- An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FY 2003 Compliance

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment services provided. Seven independent peer reviews were conducted in FFY 2003. The contracts for treatment providers require that they make staff available to perform peer reviews of other agencies in the state.

Peer Review Contract Language:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

- A maximum of five (5) days of staff time may be required during each contract period;
- The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;
- Travel expenses will be reimbursed per the Department regulations;
- Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and
- The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

FY 2005 Progress

The Division of Alcohol and Drug Abuse (ADA) facilitated seven peer reviews for FFY 2005. Reviews were conducted in each region of the state. The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the regional administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

FY 2006 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to facilitate independent peer reviews to encourage and assess the quality, appropriateness and efficacy of the substance abuse treatment being provided. Peer reviews will be scheduled in each region of the state annually. Area Treatment Coordinators will be responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report will be distributed to the regional administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator will review the report with the appropriate agency staff.

Missouri

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

For the fiscal year two years prior (FY 2004) to the fiscal year for which the State is applying for funds:

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2004 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

• the role of the single State authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;

• the role of the State Medical Director for Substance Abuse Services in the development of such procedures;

• the role of the independent peer reviewers; and

• the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

• the number of entities reviewed during the applicable fiscal year;

• technical assistance made available to the entity(ies) reviewed; and

• technical assistance made available to the reviewers, if applicable.

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment services provided. ADA has been contractually requiring all treatment providers to participate in independent peer review since July, 1993. Contracted providers have been cooperating with this requirement each year since that time. Six reviews were conducted in FY2002. Seven reviews were conducted each fiscal year in FY2003, FY2004 and FY005.

The contact between ADA and the treatment provider includes language which requires each provider to participate in the peer review process. The contract states:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:
    - A maximum of five (5) days of staff time may be required during each contract period;
    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;
    - Travel expenses will be reimbursed per the Department regulations;
    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and
    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.
2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the District in which the peer review was conducted, within ten (10) working days of completion of the review.

The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the District Administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

The agency being reviewed cooperates by providing access to client records, staff and policy and procedures documents. The reviewer utilizes this information to establish the agency's compliance with certification standards and Best Practices and is efficacious in operations. The reviewer has an opportunity to learn from another program's operations. The information is also useful to the ADA's treatment specialists and other staff that provide technical assistance to the agencies statewide. In addition to contract compliance, the role of the Area Treatment Coordinator is to provide technical

assistance and/or arrange for the technical assistance visits. Some of the feedback provided through the peer review process includes suggestions regarding treatment planning, documentation, and cultural diversity.

Federal Confidentiality Regulations are observed throughout the individual peer review process. All members of the peer review team are knowledgeable of, and agree to comply with, federal confidentiality regulations in carrying out their assigned duties.

Missouri

Goal #16: Disclosure of Patient Records

GOAL # 16.--An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).

FY 2003 (Compliance):

FY 2005 (Progress):

FY 2006 (Intended Use):

FFY 2003 Compliance

The Division of Alcohol and Drug Abuse (ADA) has complied with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and, as of April 2003, the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complied with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also required contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance have been provided to contracted program staff to ensure compliance with the federal regulations. ADA monitors the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by Regional Administrators and Area Treatment Coordinators.

FFY 2005 Progress

The Division of Alcohol and Drug Abuse (ADA) continued to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complies with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also requires contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance continue to be provided to contracted program staff to ensure compliance with the federal regulations. ADA continues to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by Regional Administrators and Area Treatment Coordinators.

FFY 2006 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA will continue to require contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance will continue to be provided to contracted program staff to ensure compliance with the federal confidentiality regulations. ADA will continue to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by Regional Administrators and Area Treatment Coordinators.

Missouri

Goal #17: Charitable Choice

GOAL #17.--An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations.

FY 2003 (Compliance): Not Applicable

FY 2005 (Progress):

FY 2006 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary ("services recipient") has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

FY 2003 Compliance

Not Applicable

FY 2005 Progress

Missouri Code of State Regulations requires that the right of an individual to not be denied admission or to receive services shall not be limited based on creed. For residential settings and where otherwise applicable, the right of an individual to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances.)

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide block grant treatment services requires that those agencies comply with the Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract providers must follow the above procedures during the course of State fiscal year 2005, ending June 30, 2005. The first report of consumer requests and referrals to essentially equivalent secular service in compliance with Charitable Choice requirement is due in July 2005.

FY 2006 Intended Use

Missouri Code of State Regulations will continue to require that the right of an individual to not be denied admission or to receive services shall not be limited based on creed. For residential settings and where otherwise applicable, the right of an individual to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances.)

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide block grant treatment services will continue to require those agencies to comply with the Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Missouri was awarded $22.8 million over three years to implement a statewide voucher system for adults that affords genuine, free and independent choice among an increased number of qualified service providers; provides recovery support services through traditional, non-traditional and faith-based organizations; expands the existing managed care system for proper control and monitoring; and measures outcomes in seven critical domains.

Faith organizations and other nontraditional providers interested in providing recovery support services under the Access to Recovery project are required to have a minimum of two staff or volunteers complete the Addictions Academy. Charitable Choice requirements are integrated into this training.

Missouri

Attachment J: Waivers

Attachment J: Waivers
If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as Attachment J to the application. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively.

Missouri

Description of Calculations

Description of Calculations

In a brief narrative, provide a description of the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the
Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations

TB Services

The Division of Alcohol and Drug Abuse (ADA) works in cooperation with the Missouri Department of Corrections (DOC), Missouri Department of Health and Senior Services (DHSS), and the Missouri Department of Social Services (DSS), Division of Medical Services to collect the information required to report the statewide non-federal cost of Tuberculosis Services provided citizens of Missouri, as well as to the substance abusers in treatment in Missouri. The statewide expenditures for tuberculosis services to substance abusers in treatment have been calculated with the following methodology.

The DOC provides aggregated costs of TB services to inmates in correctional facilities, and associated costs to those inmates in institutional substance abuse treatment programs.

The DHSS provides aggregated costs of the number of clients treated for TB by local health departments. In addition, non-federal cost of the TB tests performed at local health departments is computed for clients referred from ADA funded treatment programs.

The DSS provides statewide expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management Information System. The State Medicaid expenditures for TB treatment provided by ADA funded programs per the Department of Mental Health (DMH) Purchase of Service (POS) system are a subset of the information received from Medical Services and represent the percent of expenditures that were spent on substance abusers in treatment.

The final component of the TB cost determination is from the DMH POS system which captures services delivered to clients by service code. The payments for these non-Medicaid TB services were summed and segregated by funding source (Non-Federal or State Funds) per the POS data system.

Pregnant Women and Women with Dependent Children

The Division used the following method to calculate the amounts for the base and subsequent years for services to pregnant women and women with dependent children. The DMH POS system captures services delivered to clients by service code. For the base year 1992, all payments for services to women at programs meeting the requirements of Section 1922© and Section 96.124 (e) were summed and segregated by funding source (Federal Block Grant and Non-Federal or State Funds). The total expenditures on these qualified programs were $9,080,254 for FFY2004 and projected to be $8,163,936 for FFY2005. These amounts are greater than the required base expenditures of $7,728,020.

Missouri

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

• 42 U.S.C. 300x-29 requires the State to submit a Statewide assessment of need for both treatment and prevention.

• 42 U.S.C. 300x-51 requires the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State□s sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2006 application for SAPT Block Grant funds.

Substate Area Planning

The Missouri Department of Mental Health has five planning regions that are used by its Division of Alcohol and Drug Abuse (ADA) and Division of Comprehensive Psychiatric Services (CPS). The ADA planning regions are further divided into Service Areas consisting of clusters of counties. The largest metropolitan Service Areas comprise one or two counties while some of the rural Service Areas cover up to nine counties. In June 2000, the ADA completed a planning process that culminated in the goal of providing a full array of substance abuse services in each of ADA's 20 Service Areas. Since then, decisions regarding the placement of new or expanded services have generally been based on prioritizing the treatment or prevention needs of each Service Area and then identifying the un-served or under-served areas with the greatest unmet need. To support planning and allocation at this geographic level, needs assessment data is captured by Service Area whenever possible.

The State Treatment Needs Assessment Program (STNAP) provides estimates of substance abuse treatment need. The STNAP-I household report was finalized in 1997 and the estimates were supplemented in 1999 for non-household populations. Based on a broader household survey and a jail inmate study completed for the STNAP-II project, updated treatment needs estimates were compiled for the report *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*. The new study provided estimates for adolescents as well as adults and for each Service Area.

A recent use of the STNAP data was an analysis for primary recovery treatment expansion under the Access to Recovery CSAT grant. The focus was to identify the Service Areas of the state most in need of new or additional services for adult women, based on rankings of criteria and changes in rankings from 2000. Data from the STNAP 2003 update were used in formulating two of the five criteria -- the number of women needing treatment and the percent needing treatment who are pregnant. A third criterion was treatment penetration rates of ADA's adult female target population. Rather than defining target population using the STNAP-II estimates of the number who would seek treatment, ADA used data from the *2003 National Survey of Substance Abuse Treatment Services (N-SSATS),* which found that 80.8 percent of Missouri treatment clients received services in non-profit programs that utilize state and federal funds. That percentage was applied to the STNAP-II treatment needs estimates to determine the number who would need to access publicly supported treatment programs administered by ADA. The other two criteria used for ranking Service Area need for women's services dealt with Medicaid eligible births and availability of Medicaid eligible services.

Prevention planning and identification of highest need are ongoing processes. Data collection has evolved from community-based solely qualitative information to more effective comprehensive methods. The process has expanded the CSAP Prevention Needs Assessment Studies and has incorporated new data from other resources. Information for risk and prevalence data is captured through both qualitative and

quantitative methods. Additionally, as a pilot state for CSAP's MIS project, ADA's service providers are required to input service process information into the Minimum Data Set (MDS-3) server. The MDS-3 project collects service type, target audience, aggregate demographics of participants, and risk factors. Since the initial replication of the Missouri Student Survey in 2002, subsequent prevention initiatives have used a variety of methods and different levels of substate data collection. ADA initiatives and programs have provided the following information: specific K-12 school data and research-based program monitoring of the school-based initiative; training needs of the prevention workforce, the Prevention Works: the Next Step research project (Pentz and Hawkins); localized underage drinking information from the OJJDP EUDL discretionary awards; and binge drinking rates among college students from the CORE survey.

The one-year CSAP State Incentive Planning Grant and the five-year Strategic Prevention Framework State Incentive Grant (SPF SIG) are making a significant contribution to planning through the formation of the Governor's Substance Abuse Prevention Initiative Advisory Committee. Building on the work and information from the CSAP Prevention Needs Assessment Studies completed in the early part of the decade, the Advisory Committee and its workgroups have completed or are currently developing several projects. They conducted Hispanic and Asian focus groups in each of the state's planning regions, piloted the Tri-Ethnic Institute's Community Readiness Assessment, developed an inventory of prevention resources and activities, and prepared a prevention needs assessment report. Projects currently underway include a prevention workforce assessment and development plan; collection and analysis of state and county-level data on substance use and consequences by the State Epidemiology Workgroup, and SIG program implementation planning.

Technological advances are also part of the evolving system. ADA strives to achieve more effective and efficient ways for risk, incidence, prevalence, and highest need identification. Such progress is evident with the improvements made in capturing student information. The Student Survey was first administered to a random sample of 254 schools, 12,600 students. In 2002, the survey was replicated using state specific lessons learned and a larger sample. The 2004 Student Survey was the first to be administered over the Internet using the Smart Track application and was made available to all of the State's 524 school districts. As a result of contracting difficulties incurred by the Department of Elementary and Secondary Education (DESE) not all districts were able to participate. In spite of that problem, approximately 60,000 students, grades 6 – 12 participated in the survey. ADA and DESE have collaborated to resolve the contracting difficulties and the 2006 survey is anticipated to have 100,000 participants, making the Missouri Student Survey the largest of its type in the state.

Planning culminates with its integration into the state budgeting process. Treatment and prevention program performance and outcome measures are described and quantified in the annual budget requests of the Department of Mental Health and its divisions, including ADA. Measured performance is annually compared with projections, and new or revised decision items with plan components are developed to address deficiencies or emerging needs. During the processes of prioritizing and

justifying these proposed programs and services, additional plan details such as client eligibility, treatment methods, program locations, and management issues are clarified and elaborated.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by statute and is an advisory body to ADA and the ADA director. The SAC is comprised of 25 members appointed by the director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services, and no more than one-fourth can be ADA treatment or prevention vendors. The SAC collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current technologies and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends what specific methods, means, and procedures should be adopted to improve and upgrade the service delivery system, and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding. Five Regional Advisory Councils (RACs), representing the ADA Prevention Office's five planning regions, work with the SAC to identify and study local needs. The Prevention Office provides the administrative and logistic support for the SAC and all of the RACs.

The SAC and RACs consult with ADA's district administrators, treatment coordinators, and prevention specialists. The treatment coordinators monitor the ADA-funded treatment programs and their utilization rates and refer prospective clients to programs which are the most appropriate, accessible, and available. The prevention specialists monitor ADA-funded prevention programs and provide consultation on appropriate strategies. The district administrators gather input from their staffs, the advisory council members, and other sources to develop a thorough understanding of the service gaps in their districts with regard to locations, types of services, and populations to be served. The ADA executives utilize data from the needs assessment models and consult with the district administrators on decisions involving program expansions and reallocations. Information from these multiple sources helps ensure that ADA expends its funds to provide services in communities and for populations with the greatest needs.

The Governor's Substance Abuse Prevention Initiative Advisory Committee provides an additional advisory body. With representation from state agencies impacted by substance abuse, other stakeholders, the SAC and RAC, and service providers, and with technical support from its subcommittees and the State Epidemiological Workgroup, the Advisory Committee will have an important role in making allocation recommendations to ADA.

Public Comment in Plan Development

The Missouri Advisory Council on Alcohol and Drug Abuse, commonly referred to as the State Advisory Council (SAC), and its network of five Regional Advisory Councils (RACs) constitutes the formal mechanism that ensures that Missouri citizens have an opportunity to participate in and express their views regarding the state's publicly funded substance abuse prevention and treatment system managed by the Missouri Division of Alcohol and Drug Abuse (ADA). The SAC's statutory mandate is to collaborate with ADA to disseminate public information about alcohol and drug abuse; review current social technologies and recommend improvements to substance abuse prevention and treatment programs based upon scientific evidence; recommend what should be changed--and how--to improve and update the substance abuse service delivery system; and participate in developing standards for prevention and treatment services.

The State Advisory Council has 25 members consisting of service providers, consumers (recipients of services or family members of recipients), and other interested citizens. The Council meets regularly and holds conference calls to receive updates from ADA staff and provide feedback on budget-related matters, legislative initiatives, strategic planning and performance measurement development, and other aspects of the service delivery system. The Council appoints ad hoc committees as needed to address priority issues and make recommendations to ADA. Each RAC meets periodically and encourages discussion and analysis of local prevention and treatment issues, seeking input from individuals, agencies, and organizations involved in or impacted by substance abuse. Some RAC members also have roles as members of community-based prevention teams and coalitions, comprised of volunteers who provide leadership in substance abuse prevention, intervention, and policy development. The RAC chairpersons attend the regular meetings of the State Advisory Council and work with the SAC on various projects.

The content of the SAPT block grant application reflects recommendations generated through this citizen input. The compressed time frame for preparing the SAPT application precludes a full review by the advisory council network prior to its submission to the Center for Substance Abuse Treatment. To facilitate ongoing review, each application is posted to the ADA website at http://www.dmh.missouri.gov/ada/blockgrant.htm. ADA notifies the SAC and RAC members of the application submission, encourages them and their constituents to review it, and asks them to communicate their comments to ADA's central and district office staff for consideration in developing the next application. This process provides for ongoing access to the SAPT applications and feedback from the advisory network and the general public.

Missouri

How your State determined matrix numbers

How your State determined the numbers for the matrix

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources of data used in making these estimates. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

How your State determined the numbers for the matrix

The State Treatment Needs Assessment Program study (STNAP-II) conducted by ADA and the Research Triangle Institute (RTI) was used in determining the numbers reported on Forms 8 and 9.

Column 1: Substate planning area

The Division of Alcohol and Drug Abuse (ADA) configures Missouri into five large planning regions, each consisting of clusters of counties referred to as Service Areas. Missouri's three largest cities anchor three of these regions. Kansas City is located in the Northwest Region, St. Louis is in the Eastern Region, and Springfield is in the Southwest Region. Columbia, the fifth largest city, is in the Central Region. Cape Girardeau is the largest city in the Southeast Region.

Column 2: Total population

The population of each sub-state region listed on Form 8 is the 2003 population estimate reported by the Missouri Census Data Center.

Column 3: Total population in need

Recent estimates of treatment need are provided by the STNAP-II. Funding for the study was provided by the Center for Substance Abuse Treatment. The study was conducted during federal fiscal years 2000-2003 and included telephone surveys of household adolescents and adults, interviews with inmates in four large county jails, and collection and analysis of data from other sources. Three study reports and the Missouri Automated Integration Model (AIM) were developed from STNAP-II. AIM is a software product that generates estimates of adult substance abuse treatment need for mutually-exclusive (gender, age group, and race/ethnicity) and non-exclusive (adult pregnant women, injection drug users, and impaired traffic offenders) populations. The AIM generates estimates by planning region as reported on Forms 8 and 9 and also provides estimates for ADA's 20 Service Areas. Each Service Area is fully contained within a planning region, so the regional data is disaggregated to produce the Service Area estimates based mainly on the household survey responses in each area.

The output data from the AIM are published in the study report titled *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*. The STNAP-II study concludes that 10.4 percent of adults in households with telephones -- and 13.3 percent of adults in households without telephones -- need treatment. An estimated 37.1 percent of institutionalized adults and 36.0 percent of the homeless in Missouri need treatment. Among the incarcerated, the estimated treatment need rate is 53.4 percent for state prison inmates and 66 percent for jail inmates. An estimated 5.8 percent of household youth need substance abuse treatment. A total of 491,224 Missouri residents are estimated to need treatment services and their distribution by planning region is recorded in column 3A on form 8.

Column 3B reports estimates of the number who would seek treatment but are not currently being served. The STNAP-II household and jail interviews included questions designed to measure intent to seek treatment. Based on those responses the integrative study estimates that, among those who need treatment, 12.5 percent of the

household adults, 50 percent of the non-household adults, and 20 percent of the adolescents would seek treatment. These percentages result in an estimate of 79,135 Missouri adults and adolescents who would seek treatment – 16.1% of the population needing treatment. In state fiscal year 2004, ADA substance abuse treatment services were provided to 38,417 individuals (unduplicated count). Of these, 38,320 were Missouri residents whose county of residence – and therefore ADA planning region – are known and included on Form 8. By subtracting the residents who accessed treatment services from the 79,135 who would seek treatment, an estimated 40,815 residents who would seek substance abuse treatment did not receive services in FY2004.

Column 4: Number of IVDUs in need

Injection drug users are one of the non-exclusive populations included in the STNAP-II study's prevalence estimates. The study estimates Missouri has 12,378 injection drug users, and all of them need treatment. They are quantified by planning region in column 4A. The study does not provide estimates of the number of injection drug users who would seek treatment, but estimates that 50 percent of the non-household adults in each population group (homeless, institutionalized, and incarcerated) would seek treatment. Previously, ADA applied the 50 percent figure to the number of injection drug users needing treatment to provide an estimate of the number who would seek treatment. However, in FY2004, ADA served 5,514 Missouri residents whose method of drug administration was intravenous or intramuscular injection for their primary, secondary, or tertiary drug of abuse – 45% of the estimated treatment need. ADA served 72% of the estimated 1,875 injection drug users in the Southwest region and 65% of the estimated 1,500 in the Southeast region. Based on these penetration rates and the recognition that outreach, referral, and intervention could generate additional clients if more treatment resources were available, the figures in Form 8 are calculated using a potential treatment seeking rate of 75% of prevalence among injection drug users for a total of 9,283. By subtracting the 5,514 from the 9,283, the statewide total of 3,769 shown in column 4B constitutes the estimated number of injection drug users who would seek treatment and were not served in FY2004.

Column 5: Number of women in need

Column 5A consists of estimates of adult female treatment need derived from the STNAP-II Automated Integration Model. An estimated 144,665 adult women (age 18 and older) need treatment, and an estimated 24,159 of them would seek treatment. In fiscal year 2004, 12,063 adult women received ADA treatment services – including 12,036 Missouri residents. The number of women served by ADA in FY2004 is subtracted from the number who would seek treatment to yield 12,123 adult women remaining with an unmet need for substance abuse treatment services.

Limitation of Data in Columns 3, 4, and 5

The STNAP-II study was based heavily on the household survey of adults and adolescents. Sufficient numbers of surveys were conducted in each planning region to ensure reliable sampling by region. However, possibly as a result of smaller than desirable numbers of interviews completed and the distribution of these interviews

within some of the more finite Service Areas, estimates of treatment need were higher or lower than expected in some geographic areas. The household telephone interviews were difficult to conduct due to high refusal rates and the perception of some residents who were contacted that telephone surveys violate Missouri's No-Call list.

The prevalence estimates could potentially be improved by increasing the number of interviews, using other survey methods, conducting in-depth studies focusing on specific geographic areas, integrating the STNAP-II data with results from Missouri interviews conducted for the National Survey on Drug Use and Health, and developing a methodology to weight and integrate consumption data from surveys with standard data on substance abuse consequences. Missouri's newly-formed State Epidemiology Workgroup could use the national datasets in CSAP's State Epidemiological Data System (SEDS) to augment the survey data and update and refine the prevalence estimates if a data integration model were available.

Column 6: Prevalence of substance-related criminal activity

DWI arrests, drug arrests, and boating while intoxicated (BWI) arrests are included in the Uniform Crime Reporting (UCR) system. Data is coded according to the county of arrest and aggregated to ADA planning regions. BWI was selected for reporting in the optional column because Missouri has a large number of lakes and navigable streams. Intoxicated boating crashes and other alcohol related injuries associated with water recreation are a significant problem in the state.

Column 7: Incidence of communicable diseases

The data on hepatitis B, AIDS, and tuberculosis are provided by the Missouri Department of Health. The data are aggregated to the ADA planning regions using infected individuals' county of residence. The rate is based on the number of cases in the county per 100,000 county residents in accordance with 2003 population estimates.

Missouri

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.

Missouri

Voluntary Prevention Performance Measures

State applicants should include a discussion of topics relevant to outcome reporting in general. This would include topics mentioned in instructions above as well as any additional information (e.g., data infrastructure needs) that the State deems important. If possible, please provide the computer files and data tapes along with the application. This will allow for further analysis at the national level. Results of such analyses will be shared with the States and will be used in the development of future Performance Partnership Grant reporting activities.

Missouri continues the review of infrastructure capacity to report on the proposed SAPT Block Grant-supported program performance measures. Currently, the infrastructure includes the state's server for the Minimum Data Set, the Missouri Student Survey, and data collected through evidence-based programs implemented at the 5 SPIRIT sites.

Several data collection capacity needs have been identified and draft plans to address them utilizing the current infrastructure have been developed. Specifically, the Missouri Student Survey, scheduled for Spring of 2006, will be available to all 524 school districts as a result of switching from paper and pencil to online administration. The open fields in the Minimum Data Set have been identified as a possible collection method where applicable. Data collection will continue for the SPIRIT evidence-based program sites. In addition, a plan for pilot- and field-testing procedures and instruments for collection of National Outcome Measures has been developed and will be implemented during FFY 2006. Finally, future infrastructure capacity enhancement may be identified through Missouri's participation in the SPF-SIG IGTO (Interactive Getting to Outcomes) pilot program.